PODIATRIC REGISTRATION AND HISTORY FORM

Date ______________ Patient Name ____ SSN ___________________

Date of Birth _______________ Age _______ Gender ________________ Who referred you? ___________________

Patient Address ____

City ____ State _________________ Zip ____________________

E-Mail _______________________________________

Can we send you email with health care and appointment information? Yes or No

Mobile Phone _________________________________

Can we send you voice or text reminders? Yes or No

Home Phone ___________________________ Work Phone __________________________________

Preferred Contact Method (Circle) Mobile, Work, Home, Email

Emergency Contact

Name _______________________________ Relationship ___________________________ Phone _______________

Address ____

Can we discuss your personal health information with this person? ____

Allergies – Please state the symptom and severity

____

Medications - include over the counter, herbals, and birth control (can attach list):

____

____

What is the name and location of your preferred pharmacy? _________________________ Zip Code ___________

Height __________________________ Weight __________________________ Shoe Size ________________________

List your primary care physician ____

Last appointment date with primary care physician? ____

What is your occupation and how much time do you spend on your feet at work?

____

What type of athletics and/or regular exercise or activities are you involved in?

____

Do you smoke? If yes, than for how many years? How many packs per day?

____

Do drink alcohol on a regular basis (specify type and amount)?

____

Please tell me about your foot or ankle problem? Right or Left

Which part of foot/ankle? (Be specific)______________________________

When did the problem start?______________________________

Treatments you have tried?______________________________

Has there been any recent hospitalizations or new medical problems since your last appointment?

____

Do you have or have you had any of the following:

- ☐ Heart Disease
- ☐ Endocarditis (Heart valve infection)
- ☐ Hemodialysis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pre-Diabetic or Diet controlled Diabetes
- ☐ Diabetes controlled with oral medication
- ☐ Diabetes requiring Insulin
- ☐ Type I Diabetes
- ☐ Poorly controlled Diabetes
- ☐ History of DVT (deep vein thrombosis) or Blood Clot
- ☐ PE (pulmonary embolism)
- ☐ Clotting Disorder (factor V etc.)
- ☐ Prosthetic Joint(s) or Heart Valve Replacement
- ☐ HIV or AIDS
- ☐ Hepatitis C
- ☐ GERD (acid reflux)
- ☐ Stomach Ulcer or other GI Ulcer
- ☐ Skin Cancer or Melanoma
- ☐ Take Blood Thinners
- ☐ Stroke or CVA
- ☐ Peripheral Vascular Disease (PVD/PAD/ASO)
- ☐ Peripheral Neuropathy or Numbness in the Feet
- ☐ Foot Ulcer
- ☐ Foot Infection
- ☐ Rheumatoid Arthritis
- ☐ Other Auto-Immune Disease (Psoriasis, Lupus etc.)

Do you have any other medical problems? ______________________________

Please list any previous surgery and approximate dates: ______________________________

____

Is there a history of diabetes, blood clots (DVT/PE), clotting disorder, or cancer in your family? (please specify)

____

Female Patients: Do you take oral contraceptives or use implantable or injectable birth control? ______________

Female Patients: Are you pregnant? ________________________

I certify that the information on the front and back of this sheet is true and accurate to the best of my knowledge:

Signature ________________________Date ____________ Guardian________________________ Date____________