FOREMOST PODIATRY

COMPREHENSIVE FOOT AND ANKLE CARE

Patient Information Update Sheet

Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Phone: _____ **Alternate Phone:** _____

E-mail Address: _____ **Occupation:** _____

Emergency Contact:_____

Phone:_____ **Relationship:** _____

Primary Care Provider: _____ **Date of last visit with PCP:**_____

Preferred Pharmacy: _____ **City:** _____ **Zip:** _____

Are you Diabetic? Y / N Type 1 or 2 Most Recent Blood Sugar: _____ **Most Recent A1c%:** _____

How many falls have you had within the last 6 months? _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Allergies: _____

Medications: _____

Surgeries: _____

Do you smoke or drink? If yes, how often/how much?

_____

Do you have any of the following medical conditions:

- ☐ **Afib**
- ☐ **Clotting Disorder**
- ☐ **Foot Ulcer/Infection**
- ☐ **Heart Disease**
- ☐ **History of Blood Clot in legs or lungs**
- ☐ **HIV/AIDS/Hep C**
- ☐ **Hypertension**
- ☐ **Kidney Disease or Hemodialysis**
- ☐ **Liver Disease**
- ☐ **Peripheral Neuropathy**
- ☐ **Peripheral Vascular Disease**
- ☐ **Rheumatoid Arthritis**
- ☐ **Skin Cancer or Melanoma**
- ☐ **GERD or Stomach Ulcer**
- ☐ **Stroke or CVA**
- ☐ **Take Blood Thinners**
- ☐ **Other:** _____

Print Patient Name: _____

Patient/Guardian Signature: _____ **Date:**_____

Physician Signature: _____ **Date:**_____