Registration Form

Patient Name: ____ **DOB:** _________________

SSN: ________-_______-________ **Age** ________ **Gender:** _______

Address: ____ **City:** ___________ **State:** ______ **Zip:** _______

Phone: ____________________________________ **(Mobile / Home / Work)**

Alternate Phone: ____________________________ **(Mobile / Home / Work)**

E-mail Address: ____

May we send voice/text appointment reminders and/or email with healthcare information? Y / N

Preferred Contact Method (Circle): Mobile / Work / Home / Email

Emergency Contact:

Name: ________________________________ **Relationship:** ____________ **Phone:** __________________

Address: ________________________________ **City:** __________________ **State:** _____ **Zip:** _________

Can we discuss personal health information with this person?... Y / N

Who referred you?____

Primary Care Provider: _______________________________ **Date of last visit with PCP:**_____________

Preferred Pharmacy: ______________________________________ **City:** ______________ **Zip:** ________

Allergies: ____

Active Medications:____

____

Height: _____________ **Weight:** _______________ **Shoe Size:** ____________________

Occupation: ____

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

____

Do you drink alcohol on a regular basis? If yes, specify type and amount.

____

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? ______

Previous Surgeries:

____

____

Specify Visit Reason (Circle): Right or Left

____

____

When did the problem start? ____

Treatments Attempted:

____

What is your activity level?

____

____

Have you been evaluated for this problem by a previous physician?

____

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:** _____________

Family Medical History:

____

____

Family history of malignant hyperthermia or issues waking up from anesthesia?.................... Y / N
Family history of diabetes, blood clots, cancer?.. Y / N

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

Print Patient Name: ____

Patient/Guardian Signature: ____ **Date:**_________________

Physician Signature: ____ **Date:**_________________