WELCOME TO OUR OFFICE PATIENT # _______________OFFICE USE

PATIENT NAME: ____ **(Circle One) Mr. Mrs. Ms. Miss. Dr.**
Last First Middle Initial

DATE OF BIRTH: ______________________ **SOCIAL SECURITY # :** ______________________

PRIMARY ADDRESS:____
Street Address City State Zip

SECONDARY ADDRESS: ____
Street Address City State Zip

PHONE: HOME ________________________**CELL** ______________________**WORK** ________________________

EMAIL: ______________________________ **DRIVER'S LICENSE** ____

MARITAL STATUS: (CIRCLE ONE) MARRIED / SINGLE / DIVORCED / WIDOWED

MEANINGFUL USE INFO FOR INS. Race: __________ **Ethnicity:** ______________**LANGUAGE:** ________________

EMPLOYEMENT STATUS: (Circle One) FULL TIME / PART TIME / RETIRED / NOT EMPLOYED / DISABLED

EMPLOYERS NAME: _______________________________**EMPLOYERS ADDRESS:** _________________________

STUDENT STATUS: (CIRCLE ONE) FULL-TIME / PART-TIME
SCHOOL NAME: _________________________________**GRADE:** ____________

NAME OF SPOUSE / PARENT / GUARDIAN: ______________________________ **Phone:** ____________________

EMERGENCY CONTACT: ______________________**PHONE:** _____________________**RELATIONSHIHP:**_________

PRIMARY INSURANCE: _________________________**SUBSCRIBER (INSURED) NAME:** _______________________

SUBSCRIBER SOCIAL SECURITY # : ______________________**SUBSCRIBER DATE OF BIRTH :** __________________

SUBSCRIBER EMPLOYER: _____________________________**SUBSCRIBER WORK #:** _________________________

SUBSCRIBER EMPLOYER ADDRESS: ____

PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

SECONDARY INSURANCE : _____________________**SUBSCRIBER (INSURED) NAME:** ______________________

SUBSCRIBER SOCIAL SECURITY # :________________**SUBSCRIBER DATE OF BIRTH:** _________________________

SUBSCRIBER EMPLOYER: _________________________**SUBSCRIBER WORK #:** ____________________________

SUBSCRIBER EMPLOYER ADDRESS: ____

PATIENT OR GUARDIAN SIGNATURE: ____ **Date:** __________________

PATIENT MEDICAL HISTORY MD # ________________OFFICE USE

Patient Name: ________________________, ________________, ______ **Birth date:** ________________________
LAST FIRST MI

Reason for visit: ____ **Date of Onset:** __________________

Primary Care Physician: _______________________________________**Date Last Seen:** ____________________

Former Podiatrist: ____ **Date Last Seen:** ____________________

Date of Last Menstrual Cycle (Females Only):_________________________________ **Pregnant? Yes or No**

Medical History (check only those items that apply)

- ❑ Diabetes diet/oral/insulin ___yr
- ❑ Kidney disease
- ❑ Anemia
- ❑ Peripheral vascular dis.
- ❑ Arthritis: Rheumatoid/Osteo
- ❑ Liver disease
- ❑ High blood pressure
- ❑ GI Ulcers
- ❑ Blood disease
- ❑ Joint/Muscle Pain
- ❑ Heart disease
- ❑ Varicose veins
- ❑ Epilepsy
- ❑ Hypothyroidism
- ❑ Autoimmune disease
- ❑ Rheumatic fever
- ❑ Asthma
- ❑ Eye pathology
- ❑ Charcot joint
- ❑ Leg cramps/numbness
- ❑ High cholesterol
- ❑ CVA (stroke)
- ❑ Gastric reflux
- ❑ Joint Swelling
- ❑ Cancer Type:______________
- ❑ Heart Attack
- ❑ Murmur
- ❑ Stent
- ❑ Chest Pain
- ❑ CHF
- ❑ HIV
- ❑ Gout
- ❑ Osteomyelitis
- ❑ Other:___________
- ❑ _________________

Surgical History (check only those items that apply)

- ❑ Angioplasty
- ❑ Appendectomy
- ❑ C-section
- ❑ Cataract
- ❑ Carotid artery sx
- ❑ Gall bladder sx
- ❑ D and C
- ❑ Arterial by-pass sx
- ❑ Heart by-pass
- ❑ Open heart sx
- ❑ Hysterectomy
- ❑ Hernia repair
- ❑ Hip replacement
- ❑ Knee replacement
- ❑ Mastectomy
- ❑ Kidney stone sx
- ❑ Kidney removal
- ❑ Pacemaker/Defibrillator
- ❑ Tonsillectomy
- ❑ Prostate sx
- ❑ Venous ligation
- ❑ Breast biopsy/lumpectomy
- ❑ Back surgery
- ❑ Joint replacement
- ❑ Other:___________
- ❑ __________________

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Medications: Please list:

MEDICATION NAME	DOSAGE	FREQUENCY	PERSCRIBING DOCTOR

Pharmacy Name:_____________________ **Address:** ____________________**Phone:** ______________

Allergies (please list with reactcion)
____
____

Family History (please circle if positive)

	Diabetes	Heart disease	Cancer	High blood pressure
Mother	yes	yes	yes	yes
Father	yes	yes	yes	yes
Siblings	yes	yes	yes	yes

Social History (please check)

- ❑ Alcohol
- ❑ Tobacco____ PPD
- ❑ Caffeine
- ❑ Activities____

HOSPICE/HOME HEALTH: Are you CURRENTLY under the care of hospice/home health? YES or NO (circle one)
Facility Name: ____ **Date put in hospice/home health:** _________________