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INITIAL PATIENT INFORMATION SHEET

In order to facilitate treatment please fill in all blanks.

Name:_____

Family Physician:_____ Physician Phone No. _____

Reason for visit today:_____

_____

Have you been to a Podiatrist before?_____Yes _____No. If yes, who_____

Have you ever had FOOT or ANKLE surgery before? _____Yes _____No. If yes, what type of surgery? _____

MEDICAL HISTORY

Heart Attack_____	Yes	No	Parkinson's Dz._____	Yes	No
High Blood Pressure_____	Yes	No	Heart Problems_____	Yes	No
Diabetes_____	Yes	No	Artificial Joints_____	Yes	No
Hepatitis A,B,C_____	Yes	No	Vascular Disease_____	Yes	No
Cancer_____	Yes	No	Mitral Valve Problems__	Yes	No
Vision Problems_____	Yes	No	Bleeding Problems_____	Yes	No
Stroke_____	Yes	No	Stomach Problems_____	Yes	No
Sinus_____	Yes	No	Arthritis....type_____	Yes	No
Thyroid_____	Yes	No			

Allergies to Medicine - Circle

sulfa penicillin novocain
tape iodine antibiotics
other_____
_____
_____

Are you pregnant?_____
Height_____ Weight_____

Past Surgeries.....list please

_____
_____
_____
_____
_____

Current Medications - See Attached List (ask front desk for sheet)

_____ _____ _____
_____ _____ _____

Have you ever smoked? _____Yes _____No If yes, how much? _____ How long? _____
Do you drink alcohol? _____ Yes _____No If yes, how often?_____