WELCOME TO OUR OFFICE

NAME: (LAST)____(FIRST)_______________________________________

Address:____ Social Security No:______________________

City:____State:____________ Zip Code:_______________

Home Phone:____ Marital Status: S___ M___ W___ D___

Birthdate:____ Age:___________ Sex:_____

Employer:____Job Title:____________________________

Employer Address:_______________ Employer Phone No:_______________

City:____State:____________ Zip Code:_______________

Your Email address:____

Whom should we contact in case of emergency?

Name:______________________________________ Relationship:________________Address:____

Telephone:__________________City:___________________________________ State:____________ Zip Code:____________________________

Social Security Number:______________________

INSURANCE INFORMATION:

******Primary Insurance

Name of Company:____

Address:____ City:_______________________ State:_______ Zip Code:_________

Insured's name:______________________________ Insured's Date of Birth:_________________

Policy Number:____________________________ Group Number:__________________________

Insurance Telephone Number:____

******Secondary Insurance

Name of Company:____

Address:____ City:_______________________ State:_______ Zip Code:_________

Insured's name:_________________________ Insured's Date of Birth:______________Policy Number:__________ Group Number:_________

Insurance Telephone Number:____

HOW DID YOU HEAR OF OUR OFFICE:

Patient___ Physician___ Newspaper___ Phonebook___ Internet___ Other____If patient or physician, whom: ___________________________________

Please read and sign the statement below:

"I hereby give my permission to Podiatry Associates of Erie, Inc. to administer treatment and/or to perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot problem. I understand I am responsible for the charges for these procedures:"

Signature:____________________________________ Date:______________________________

Signature of Patient or Guardian

WE ARE PLEASED TO HAVE YOU AS A PATIENT. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

Patient Name:____ Pt. No.______________________________

Home/Work Phone Numbers: (____)_________________________ H (____)_______________________________W

Height:_________ Weight:_________ Shoe Size: _________ Employment:___________________________________ Age:_________ Sex: M / F

Primary Care Physician:_________________ _________________ City:_______________________________________

First Last

Your last check-up by your Doctor: Month_________ Year_________ Unknown_________

If you are female, to your knowledge, are you pregnant? Yes_________ No_________

Foot Problems:____

Past Treatment(s):____

If yes, by whom:____ When:__________________________________

MEDICAL HISTORY

IF YOU WERE TREATED IN THE PAST, OR ARE NOW BEING TREATED FOR ANY OF THE ILLNESSES PLEASE PLACE A (✓) NEXT TO THE PROPER ILLNESS: DO NOT PUT YES OR NO IN EACH SLOT.

- ☐ AIDS
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding
- ☐ Blood Transfusion(s)
- ☐ Cancer (type):
- ☐ CHF (Congestive Heart Failure)
- ☐ Diabetes: Type I___ Type II___
- ☐ Edema (swelling)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Problems (type)
- ☐ Hepatitis (type)
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stomach Ulcer/Hiatus Hernia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vein/Artery Disease
- ☐ Venereal Disease

Other____

CHILDHOOD ILLNESS (✓)

- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Rubella (German Measles)
- ☐ Scarlet Fever
- ☐ Tuberculosis

Please list Any other illness you feel we should be aware of:____

ALLERGIES

Have you experienced ANY ALLERGIC REACTIONS to the following: (✓)

☐ Aspirin	☐ Iodine	☐ Sulfa
☐ Bee Sting	☐ Neosporin	☐ Tape
☐ Chemical(s)	☐ Novocain	☐ Tylenol
☐ Clothing	☐ Penicillin	☐ X-ray dye
☐ Codeine	☐ Rag weed, Pollen	☐ Other (metals, etc.)
☐ Foods	☐ Steroids (Cortisone)	☐ Other antibiotics

Other____

BLEEDING/SCARRING PROBLEMS (✓)

	YES	NO
Bruise easily		
Clotting problems		
Frequent nose bleeds		

	YES	NO
Sickle cell disease		
Sickle cell trait		
Scar poorly		

Blood Transfusions: Yes___ No___ IF Yes Year(s)________ Reason:_______________________________________

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICINES

Name of Drug	Dosage	Purpose of Medication
1.		
2.		
3.		
4.		
5.		
6.		

No Medications at this time: _____Women: List Birth Control Pill if applicable: ______________________________

*Do you routinely take aspirin or other anti-inflammatory medicines (Advil, Alleve, etc.)? Yes_____ No_____

PRIOR SURGERY(S)

List your MOST RECENT surgery(s), even if done years ago. Please list the name of the hospital, out-patient surgery center, doctor, year, etc. if possible.

1. No prior surgery(s):_____

2. (a) Type of surgery_____________________________________ Year_________ Location____

   (b) Type of surgery_____________________________________ Year_________ Location____

   (c) Type of surgery_____________________________________ Year_________ Location____

   (d) Type of surgery_____________________________________ Year_________ Location____

3. Were there ANY adverse reactions to medication or anesthesia before, during, or after your surgery? Yes_____ No____

If yes, list REACTION(S):_______________________________________ 4. Did you heal from your surgery WITHOUT ANY complications? Yes_____ No______

If no, list COMPLICATION(S):____

FAMILY HISTORY

*Please list ONLY the FOLLOWING FAMILY MEMBERS who have these illnesses or who have passed away from these illnesses: Mother, Father, Sisters, Brothers, Grandparents (maternal/paternal).

	Relative	Living (✓)	Age at Passing
Cancer (type):			
Clotting Problems:			
Diabetes:			
Foot Problems:			
Gout:			
Heart Disease:			
High Blood Pressure:			
Stroke:			
Thyroid Problems:			

SOCIAL HISTORY

Marital Status: M_____ S_____ D_____ W_____ Sep_____

Smoker: Yes_____ No_____ Packs/day_______ Years_______

Alcohol: Yes_____ No_____ How often and how much___________________________

Recreational Drugs: Yes_____ No_____

Caffeine Consumption: Regular Yes_____ No_____ Cup(s)/day_____

(coffee, tea, soda) Decaff Yes_____ No_____ Cup(s)/day_____

Exercise: No_____ Yes_____ type____

Hobbies:____

Have you ever been treated by a podiatrist before? Yes_____ No_____

If so, what did he/she treat you for?____