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 Telephone No:_____
City:_____State:_____ Zip Code:_____
Your E-mail address:_____
Whom should we contact in case of emergeny?

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___ TV___ Radio___ 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

Patient Information

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:_____ Employement:_____

Age:_____ Sex: M / F

Personal Pysician:_____ _____ 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.

1. AIDS		16. Heart Problems (type)	
2. Anemia		17. Hepatitis (type)	
3. Angina		18. Hypertension (High Blood Pressure)	
4. Arthritis		19. Hypotension (Low Blood Pressure)	
5. Asthma		20. Kidney Problems	
6. Bleeding		21. Liver Problems	
7. Blood Transfusion(s)		22. Lung Problems	
8. Cancer (type):_____		23. Phlebitis	
9. CHF (Congestive Heart Failure)		24. Pneumonia	
10. Diabetes: Type I____ Type II_____		25. Rheumatic Fever	
11. Edema (swelling)		26. Stomach Ulcer/Hiatus Hernia	
12. Emphysema		27. Stroke	
13. Epilepsy		28. Tuberculosis	
14. Glaucoma/Cataracts		29. Vein/Artery Disease	
15. Gout		30. Venereal Disease	

Other_____

CHILDHOOD ILLNESS (✓)

1. Chicken Pox		5. Rubella (German Measles)	
2. Measles		6. Scarlet Fever	
3. Mumps		7. Tuberculosis	
4. Rheumatic Fever			

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

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

1. Aspirin _____		7. Iodine _____		13. Sulfa _____	
2. Bee Sting _____		8. Neosporin _____		14. Tape _____	
3. Chemical(s) _____		9. Novocain _____		15. Tylenol _____	
4. Clothing _____		10. Penicillin _____		16. X-ray dye _____	
5. Codeine_____		11. Rag weed, Pollen		17. Other (metals, etc.)	
6. Foods_____		12. Steroids (Cortisone)		18. Other antibiotics	

Other_____

BLEEDING/SCARRING PROBLEMS (✓)

	YES	NO		YES	NO
1. Bruise easily			4. Sickle cell disease		
2. Clotting problems			5. Sickle cell trait		
3. Frequent nose bleeds:			6. Scar poorly		

Blood Transfusions: Yes_____ No_____ IF yes Year(s) _____ Reason: _____

Over please

Patient Information side 2

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 antiinflammatory 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) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
   (b) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
   (c) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
   (d) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
   (e) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
   (f) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
   (g) Operation:_____ Doctor:_____ Year:_____
   Performed in: Hospital _____ Surgical Center_____ Office _____
3. Were there ANY adverse reactions to medications or anesthesia before, during, or after your surgery? Yes____ No____
   If yes REACTION(s):_____
4. Did you heal from your surgery WITHOUT ANY complications? Yes_____ No_____
   If yes 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? _____