Health@Care

PODIATRY NEW PATIENT FORM

Last Name First Name MI		Social Security # - -	Birthdate
Street Address		Gender (circle one) M F	Birthplace
City State Zip		Home phone	Mobile phone
E-mail address		Work phone	Fax
Occupation	Employer		
Emergency Contact Name	Emergency Contact relationship	Emergency Contact phone number	
Pharmacy name	Pharmacy address or intersection		
How did you hear about us?			
Who is your Primary Care Physician?			

INSURANCE INFORMATION		
	PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
ID#:		
GROUP #:		
SUBSCRIBERS NAME:		
SUBSCRIBERS DOB:		
RELATIONSHIP TO PATIENT:		

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Name:_____ **Birthdate:**_____ **Date:** _____

PERSONAL MEDICAL HISTORY

Please check past or present history of the following conditions:

Past	Present	Condition
		GENERAL
☐	☐	Transfusion (year:_____)
		EYES
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Macular Degeneration
		EAR/NOSE/MOUTH/THROAT
☐	☐	Hearing loss
		CARDIOVASCULAR
☐	☐	Heart attack/Heart disease
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	Pacemaker
☐	☐	PAD (Peripheral artery disease)
		PULMONARY
☐	☐	Asthma
☐	☐	COPD / Emphysema
☐	☐	Pneumonia
		GASTROINTESTINAL
☐	☐	Liver disease
☐	☐	Reflux (GERD)
☐	☐	Ulcers (stomach, duodenal)
		GENITOURINARY
☐	☐	Kidney/bladder infections

Past	Present	Condition
		MUSCULOSKELETAL/RHEUMATOLOGICAL
☐	☐	Arthritis
☐	☐	Gout
		SKIN
☐	☐	Eczema/Dry skin (circle one)
☐	☐	Psoriasis
☐	☐	Other: _____
		NEUROLOGIC
☐	☐	Headaches
☐	☐	Seizures/Fits/Epilepsy
☐	☐	Stroke
		PSYCHIATRIC/DEPENDENCY
☐	☐	ADD/ADHD
☐	☐	Alcohol/Drug Dependency
☐	☐	Bipolar Disorder
☐	☐	Depression
		ENDOCRINE
☐	☐	Diabetes (sugar)
☐	☐	Hyperthyroid (high thyroid)
☐	☐	Hypothyroid (low thyroid)
☐	☐	Osteoporosis / Osteopena

Past	Present	Condition
		BLOOD/LYMPHATIC/CANCER
☐	☐	Anemia/Low blood counts
☐	☐	Blood clots
☐	☐	Cancer: (Type:_____)
☐	☐	Easy bleeding
☐	☐	Sickle cell anemia
		ALLERGIC/IMMUNOLOGIC
☐	☐	Hay fever/Pollen allergy
		INFECTIONS
☐	☐	AIDS/HIV
☐	☐	Hepatitis: Circle which: A B C)
☐	☐	Rheumatic fever
☐	☐	Shingles
		MEN ONLY
☐	☐	Enlarged prostate (BPH)
		WOMEN ONLY
☐	☐	Abnormal uterine bleeding

Please tell us the main reason for your visit today:

_____

_____

Height_____ Weight_____ Shoe Size _____

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Name:_____ **Birthdate:**_____ **Date:** _____

MEDICATIONS Please list medications you currently use with dosages and frequencies. Please include over-the-counter and herbal medications.					
Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**
		time(s) per day			time(s) per day
		time(s) per day			time(s) per day
		time(s) per day			time(s) per day
		time(s) per day			time(s) per day
		time(s) per day			time(s) per day
		time(s) per day			time(s) per day

MEDICATION ALLERGIES Please list any drug allergies and the type of reaction you experience with each drug		
Medication	**Reaction**	**Age When Occurred**

GENERAL CONSENT FOR TREATMENT (REQUIRED)

I,_____, knowing that I require diagnostic, medical and/or surgical care and/or treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of my physician or his/her designee as is necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination by my health care provider.

_____ _____

Signature Date