

Park Avenue Podiatric Care, PLLC

Patient Information

Last Name _____ First Name _____

Address: _____ Apt # _____

City/State _____ ZIP _____

Home Phone # (_____) _____ Cell # (_____) _____

Emergency Contact # (_____) _____

Sex: Male Female Birth Date _____ Age _____ Single Married
Other _____

Social Security # _____

Student: Yes No

Are you employed? NONE FULL TIME PART TIME RETIRED

Employer: _____ Work # (_____) _____ ext _____

General Physician's Name _____ Date of Last _____

General Physician's # (_____) _____

How did you hear about our office: Yellow Pages Website Insurance Friend
 Family Other _____

Primary Insurance

Insurance company: _____

Policy # _____ Group # _____

Subscriber (If other than Patient) Spouse Parent Other

Last Name _____ First Name _____

Social Security # _____ Birth date (Subscriber) _____

Park Avenue Podiatric Care, PLLC

Patient Medical History

Name: _____ Date _____

CHIEF CONCERN

Please describe your current foot problem: _____

How long have you had this problem? _____

Describe the onset: Sudden Gradual

Since onset the problem has: Worsened Improved Not Changed

Describe any previous treatments for your current problem: _____

Past Medical History

Have you ever been DIAGNOSED with any of the following?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis Osteo | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Arthritis Rheumatoid | <input type="checkbox"/> Gastro-Esophageal | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Reflex Disease (GERD) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Nervous Disorders | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell | |

List **all** past surgeries (not limited to feet): _____

MEDICATIONS AND ALLERGIES

MEDICATIONS (Please list all current prescriptions and over the counter medications):

NONE _____

Allergies: Adhesive Tape Aspirin Codeine Iodine Latex Local Anesthetic
 Malignant Hyperthermia Metal Penicillin Sulfa Other _____

Reactions: _____

Do you smoke? NO YES _____
(Packs per day)

Do you drink alcohol? NO YES

Frequency: Occasionally Frequently Rarely

Does your family have a history of foot problems? NO YES _____
Please list all problems

Have you ever experience any of the following problems with your feet:

Burning Coldness Cramping Dryness Excessive Sweating Weakness
 Numbness Pain Redness Swelling Ulcers Itchiness Other _____
 NONE