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?

☐ Anemia	☐ Claustrophobia	☐ High Blood Pressure	☐ Stomach Ulcer
☐ Aids	☐ Depression	☐ High Cholesterol	☐ Stroke
☐ Angina	☐ Emphysema	☐ HIV	☐ Thyroid Disease
☐ Anxiety Disorders	☐ Fibromyalgia	☐ Kidney Disease	☐ Tuberculosis
☐ Arthrites Osteo	☐ Gout	☐ Liver Disease	☐ Varicose Veins
☐ Arthritis Rheumatoid	☐ Gastro-Esophageal	☐ Migraine Headaches	☐ Diabetes
☐ Asthma	Reflex Disease (GERD)	☐ Mitral Valve Prolapse	☐ Other
☐ Bleeding Disorder	☐ Heart Arrhythmia	☐ Nervous Disorders	
☐ Blood Clots	☐ Heart Disease	☐ Seizures	
☐ Cancer	☐ Hepatitis	☐ 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 ☐ Itchniess ☐ Other_____
☐ NONE