PATIENT INFORMATION

NYC FOOT & ANKLE CENTER

2599 Broadway | New York, NY 10025 | O: (212) 663-3668 | F: (212) 663-3995 | greatfeets.com

PATIENT INFORMATION

Date: _____

SSN: _____

Patient Name: _____

_____

Name you wish to be called: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced

Patient Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's/Partner's Name: _____

Whom may we thank for referring you? _____

_____

_____

PHONE NUMBERS

Home Phone: _____

Cell Phone: _____

Best time and place to meet you: _____

In Case of Emergency Contact

Name: _____

Relationship: _____

Home Phone: (____) _____

Work Phone: (____) _____

PRIVACY INFORMATION

May we leave an impointment message...

On your home phone (including auto call)?	Y	N
On your mobile phone (including auto call)?	Y	N
By mobile text (including auto call)?	Y	N
On your office voicemail?	Y	N
With another person?	Y	N
Via mail?	Y	N
Via email?	Y	N

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh, back and hip complaints): _____

_____

_____

Have you ever been to a podiatrist before? ☐ Y ☐ N *If yes, please list.*

Name: _____

Last Visit: _____

Is there any personal or family history of diabetes? ☐ Y ☐ N

Your Occupation: _____

Cigarette/Tobacco Use: _____

Years You Smoked: _____

Athletic Activites in Which You Participate: _____

_____

_____

Check the boxes for problems you now have or have had in the past.

- ☐ Ankle Pain
- ☐ Athlete's Foot
- ☐ Bunions
- ☐ Coms/Calluses
- ☐ Feet/Leg Cramps
- ☐ Flat Feet
- ☐ Hammer Toes
- ☐ Fungus
- ☐ Fungus
- ☐ Heel Pain
- ☐ Ingrown Toenails
- ☐ Numbness in Feet/Legs
- ☐ Plantar Warts
- ☐ Swelling in Ankles/Feet

MEDICAL HISTORY

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Please indicate if you ever had any of the following:

AIDS/HIV	Y N	Diabetes	Y N	Radiation Treatment	Y N
Allergies to Anesthetics	Y N	Ear Problems	Y N	Rash	Y N
Allergies to Medicine or Drugs	Y N	Epilepsy	Y N	Respiratory Disease	Y N
Anemia	Y N	Eye Problems	Y N	Rheumatic Fever	Y N
Angina	Y N	Fainting	Y N	Shortness of Breath	Y N
Anxiety Disorders	Y N	Gout	Y N	Sinus Problems	Y N
Arthritis	Y N	Headaches	Y N	Special Diet	Y N
Artificial Heart Vales or Joints	Y N	Heart Disease	Y N	Stroke	Y N
Asthma	Y N	Hemophilia	Y N	Swollen Neck Glands	Y N
Back Problems	Y N	Hepatitis/Jaundice	Y N	Tuberculosis	Y N
Bleeding Disorders	Y N	High Blood Pressure	Y N	Ulcers	Y N
Cancer	Y N	Kidney Problems	Y N	Varicose Veins	Y N
Chemical Dependancy	Y N	Liver Disease	Y N	Veneral Disease	Y N
Chest Pain	Y N	Low Blood Pressure	Y N	Weight Loss, unexplained	Y N
Chronic Diarrhea	Y N	Neuropathy	Y N		
Circulatory Problems	Y N	Phlebitis	Y N		
Depression	Y N	Psychiatric Care	Y N	**Pregnant**	Y N

Surgeries You Have Had/Dates: _____

_____

Hospitalizations Other Than for the Surgeries Listed: _____

_____

Family Physician: _____ Last Visit Date: _____

Phone: _____ Address: _____

_____

Are you now or have you ever been under any other doctor's care for any reason over the past two years? Y N

If so, please explain: _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications, and vitamins: _____

_____

Pharmacy name(s): _____

Pharmacy phone(s): _____

Do you take oral contraceptives? Y N

ALLERGIES

- ☐ Adhesive Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Other
- ☐ Local Anesthetics
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafood
- ☐ Sufla
- ☐ Latex

Treatment Consent I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform diagnostic procedures including x-rays, and medical care upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date