EASTSIDE PODIATRY

Patient Name_____**AGE**_____D**OB**_____

Spouse_____If Minor, parent/guardian's name_____

Marital status, please circle one: Single Married Domestic Partner Separated Divorced Widowed

Race: ___White/Caucasian ___Black/African-American ___Other If other, please list:_____

Ethnicity: ___Spanish/Hispanic ___Non-Hispanic Primary Language:_____

Address_____

Home Phone_____**Cell Phone**_____**Work Phone**_____

Occupation_____ **Place of Employment**_____

Person to notify in case of emergency_____**Phone #**_____

Do you have health insurance? ___Yes ___No **PLEASE HAVE CARDS READY FOR SCANNING**

Name & DOB of insured if other than self_____

Primary Care Physician_____**Pharmacy**_____

How is your general health? ___Good ___Fair ___Poor **Date of last PCP visit**_____

Are you under a physician's care now for any reason? ___Yes ___No _____

Please list any medications taken _____

_____

MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Diabetes High Blood Pressure Shortness of Breath Rheumatic Fever Stomach Ulcer
Difficulty healing when cut Heart Disease Other_____

Have you had an allergy/reaction to any of the following? (PLEASE CIRCLE ALL THAT APPLY)

Penicillin Aspirin Cortisone Codeine Foods Latex Novocain
Adhesive tape Other_____ Reaction_____

What is your present foot problem/duration?_____

Have you ever been treated by a Podiatrist?____Yes____No **Date of last visit**_____

Did anyone refer you to this office? ___Yes___No Name_____

I hereby give my permission to Eastside Podiatry to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature_____**Date**_____