Allegheny Podiatry Management, L.L.C.
NEW PATIENT INFORMATION SHEET

DATE: ______________________________

INSURANCE ______________________________

PLEASE PRINT
Miss/Mrs/Ms/Mr/Master/Dr/Sister (circle)

SOCIAL SECURITY NO. ____________________

RACE (circle) Asian/Black/Hispanic/White/Other______________

FULL NAME ______________________________ AGE ______ DATE OF BIRTH ______________

ADDRESS ______________________________ CITY ________________ STATE ______ ZIP __________

HOME PHONE ________________ WORK PHONE ________________ CELL PHONE ________________

HEIGHT __________ WEIGHT _________ SHOE SIZE ______ OCCUPATION ______________________

EMERGENCY CONTACT, RELATIONSHIP, PHONE NO ______________________________

EMAIL ADDRESS:______________________________ Is foot/ankle problem a work injury? _________

WHAT IS YOUR CURRENT FOOT PROBLEM? (include which foot, toe, area) ______________________

____

PRIMARY MEDICAL DOCTOR, ADDRESS, PHONE NO ______________________________

____Date of Last Visit with PCP___________

WHO REFERRED YOU TO OUR OFFICE? (inc. address) ______________________________

GENERAL HEALTH – If you had or now have any of the following, please check below:

( ) Anemia
( ) Anxiety
( ) Asthma/Bronchial
( ) Arthritis
( ) Blood Disorder/Hemophiliac
( ) Cancer ________________
( ) Cerebral Accidents/Stroke
( ) Depression
( ) Diabetes-Insulin
( ) Diabetes-Non Insulin
( ) Emphysema
( ) Epilepsy
( ) Gastric Ulcer
( ) Gastrointestinal Disorders
( ) Hiatal Herna
( ) Glaucoma
( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) HIV
( ) Hypertension
( ) Hypotension
( ) Hyperthryoidsm
( ) Hypothryoidism
( ) Hypertropic Scar
( ) Mental Illness
( ) Peripheral Vascular Disease
( ) Renal Disorders
( ) Rheumatic or Scarlet Fever
( ) Sickle Cell Abnormality
( ) Thrombophlebitis
( ) Tuberculosis

( ) Other ____

PLEASE LIST CURRENT MEDICATIONS ______________________________________

____

PHARMACY NAME, ADDRESS, PHONE ______________________________________

DO YOU SMOKE? No ____ Former _____ Yes ____ IF YES, HOW LONG? ______________________

ALLERGIES (Please check)

( ) Adhesive Tape
( ) Betadine
( ) Codeine
( ) Cortisone
( ) Novocaine/Local Anesthetics
( ) Other Antibiotics ___________________
( ) Sulfa
( ) Penicillin

( ) Other ____

PLEASE LIST SERIOUS OPERATIONS (include foot surgery) ______________________________

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HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? _________ WHEN WAS YOUR LAST VISIT? ______________

FAMILY HISTORY (If immediate family member has or had one of the following, please check)

( ) Asthma
( ) Arthritis
( ) Cancer
( ) Diabetes Mellitus
( ) Gout
( ) Heart Disease
( ) Hypertension/High Blood Pressure
( ) Peripheral Vascular Disease
( ) Other ______________________________

TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND BY MY SIGNATURE BELOW, I CONSENT TO TREATMENT FOR MY FOOT AND ANKLE PROBLEMS: (If patient is a minor, parent/legal guardian must sign)

x____
Patient Signature