

WESTBOROUGH PODIATRY, LLC

45 Lyman Street • Chauncy Place • Suite 10 • Westborough, Massachusetts 01581

Office: 508-836-0200 • Fax: 508-836-0282

PATIENT INFORMATION FORM

(Please Print)

Date: ____/____/____

PATIENT NAME:

Last

First

MI

____/____/____
Date of Birth

Age

Sex: M F

Home Address: _____ City/State: _____ Zip: _____

May we leave a message?

Home Phone #: (____) ____-____ Yes No

Work Phone #: (____) ____-____ Yes No

Cell Phone #: (____) ____-____ Yes No

Email: _____ Yes No

Primary Language: _____

Do you have a legal guardian or healthcare power of attorney? Yes No

If yes, Name: _____ Relationship: _____ Phone #: (____) ____-____

Emergency Contact: _____ Relationship: _____ Phone #: (____) ____-____

Primary Care Doctor: _____ Phone: _____

Local Pharmacy: _____

Is there a family member or other person you would like for us to share your medical information?

____ Yes Name(s) _____

____ No

Who referred you to us? _____

INSURANCE INFORMATION

Disregard if you have provided us with your card(s)

Primary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) ____-____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____

Secondary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) ____-____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements): If you have a list please provide.

Name	Dose	How often do you take?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please list all prior hospitalizations (other than for surgery):

Reason For Hospitalization	Date	Reason For Hospitalization	Date

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse

☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit - How long ago? _____ ☐ Smoke ____ packs/day for ____ years

Use of Recreational Drugs: ☐ Never ☐ Quit - How long ago? _____ Type _____

☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times a week ☐ Daily

Types of exercise: _____

FAMILY HISTORY

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure

☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

☐ Other _____

YOUR MEDICAL HISTORY

Allergies: ☐ Medications _____

☐ Anesthesia _____ ☐ Foods _____

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other _____

☐ None Known

Have you ever had any of the following?

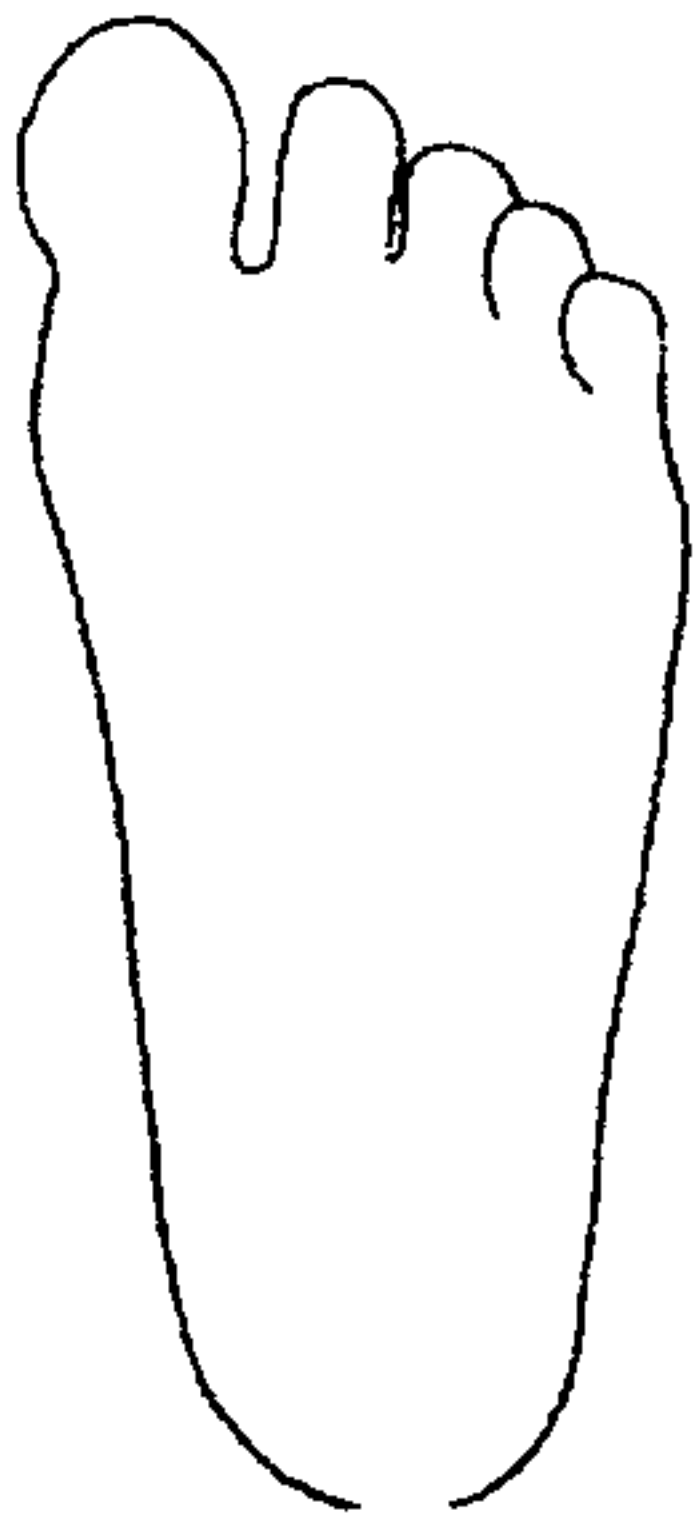
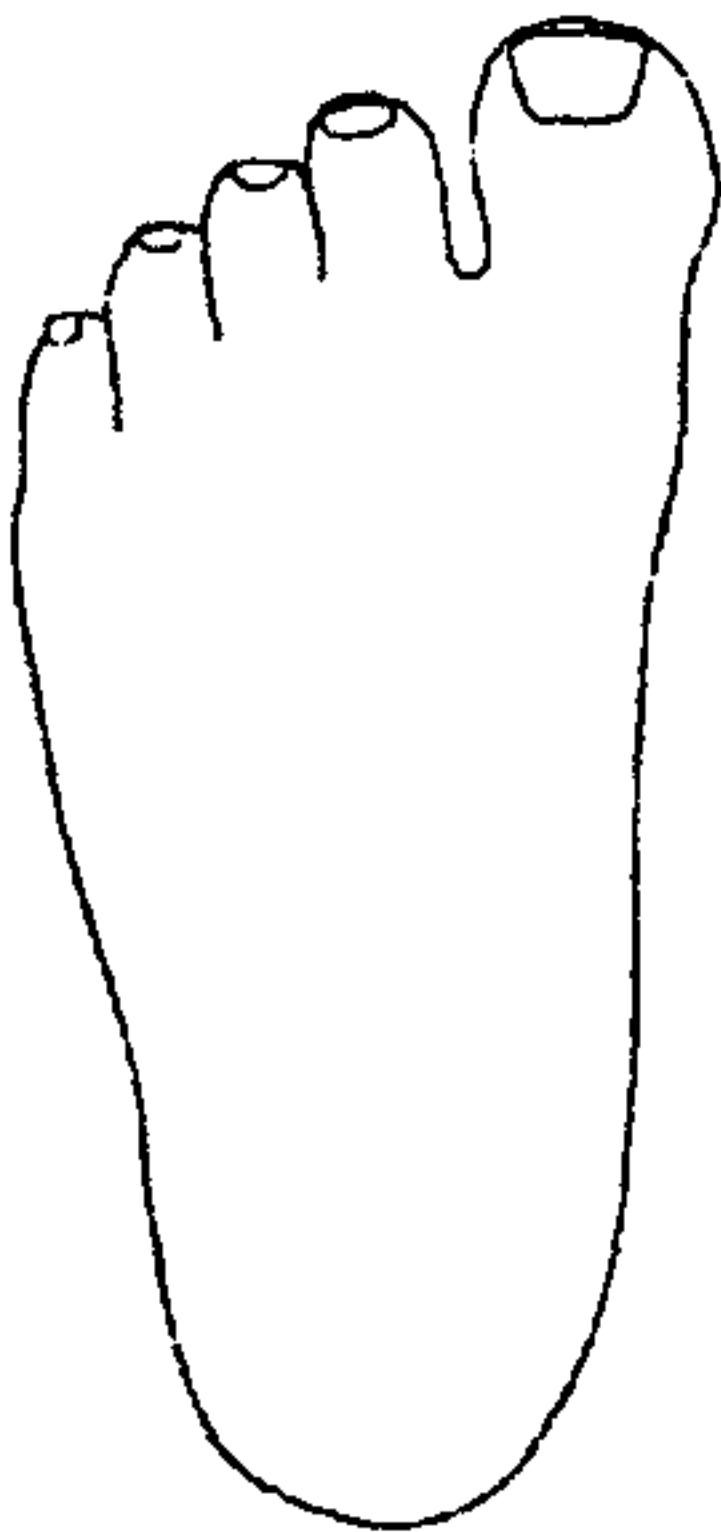
Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease / Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+ / AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Other Conditions:								

CURRENT PROBLEM

What specific problem brings you to our office today? _____

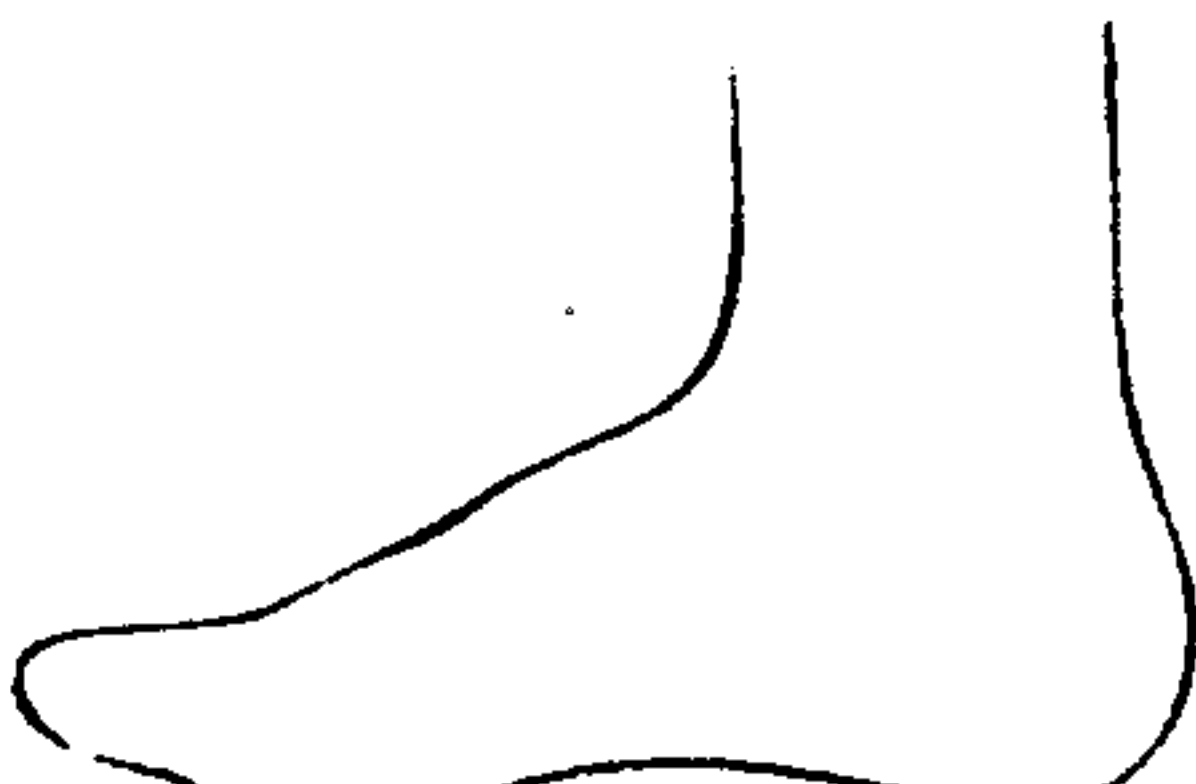
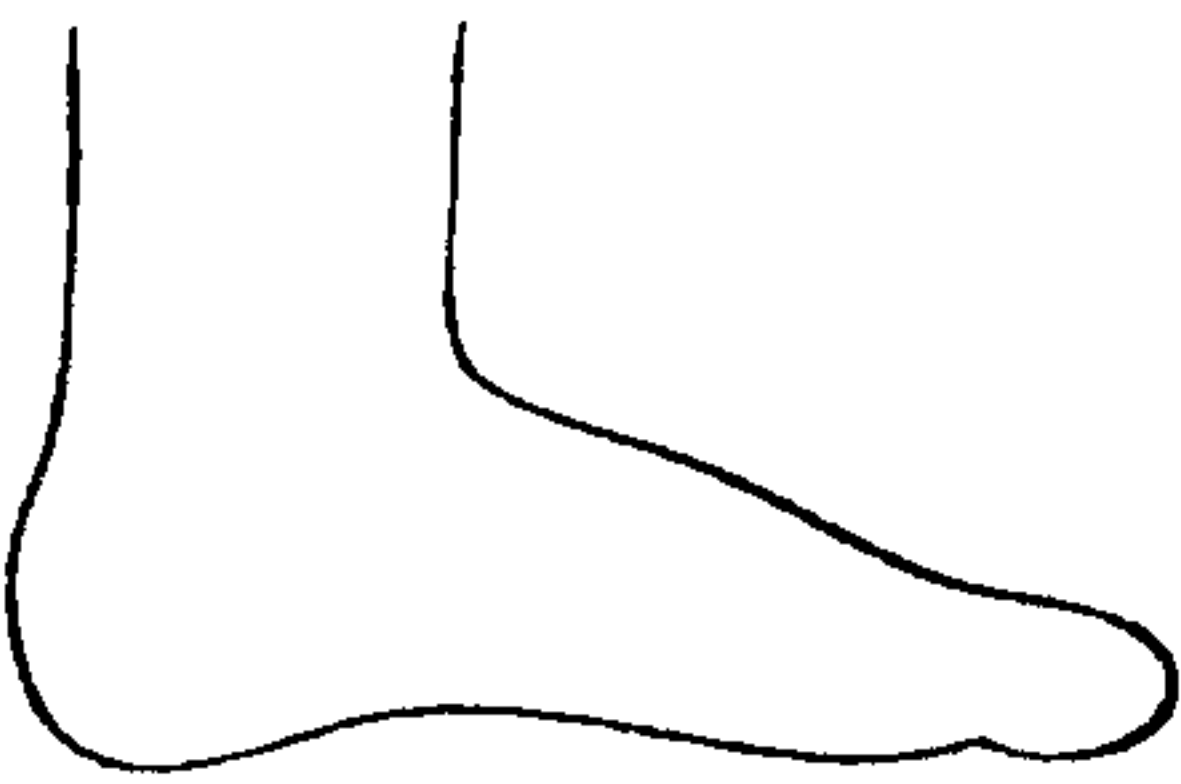
Where is the pain / problem located? Please mark on the pictures below.

LEFT FOOT



Top of Foot

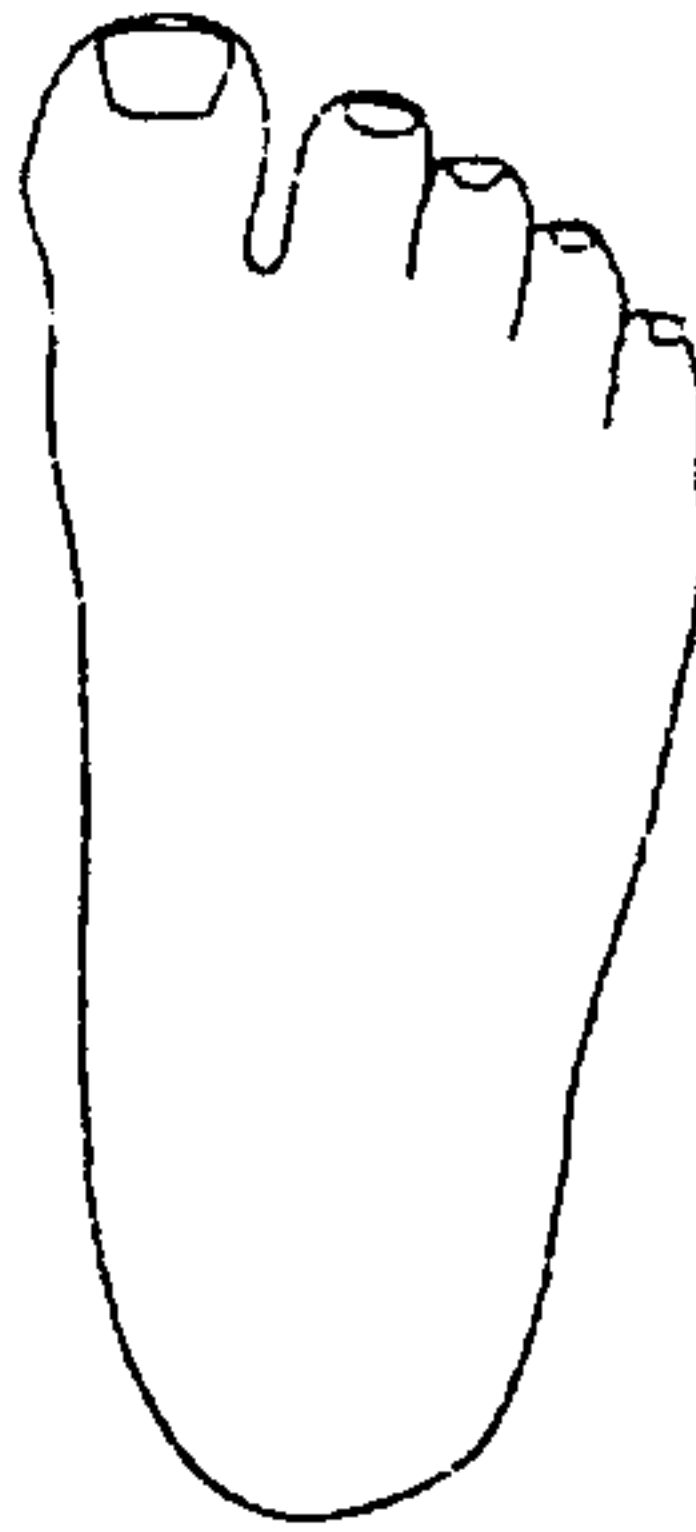
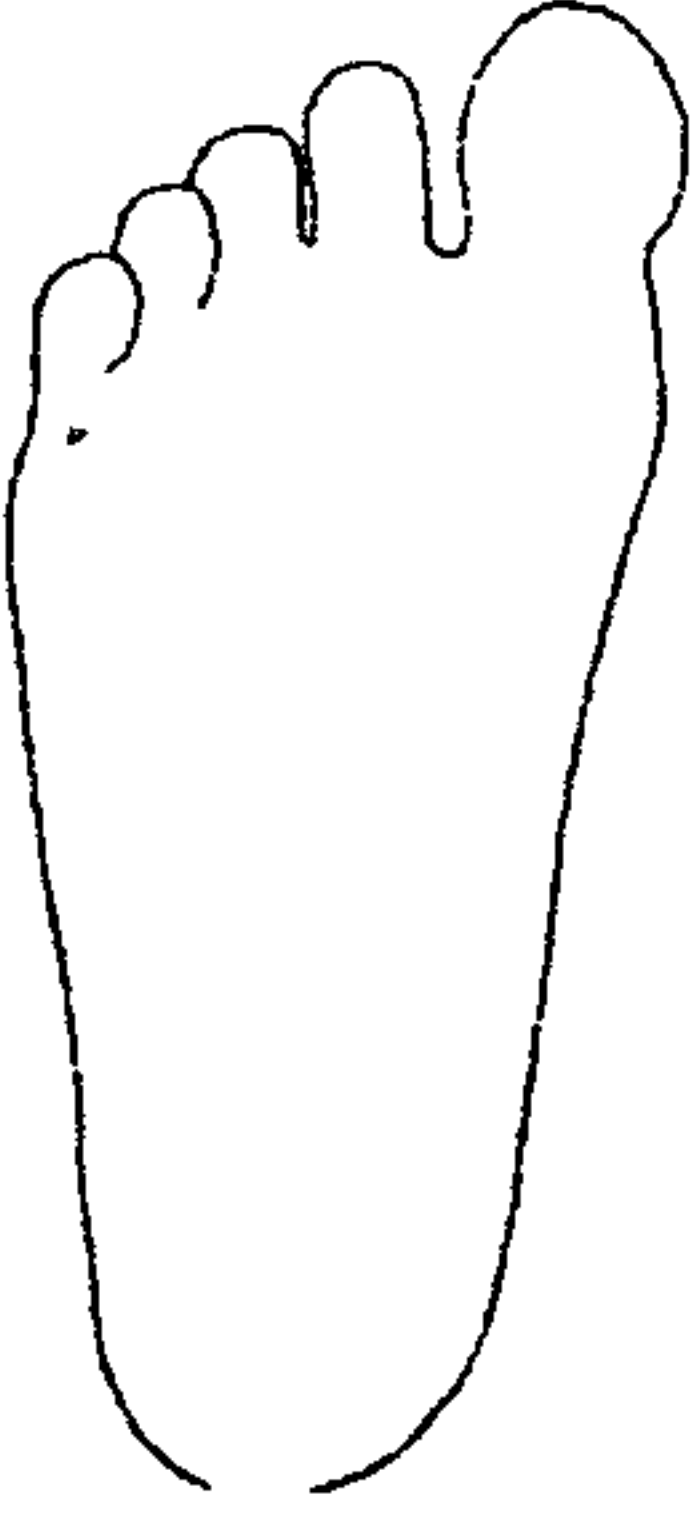
Bottom of Foot



Inside of Foot

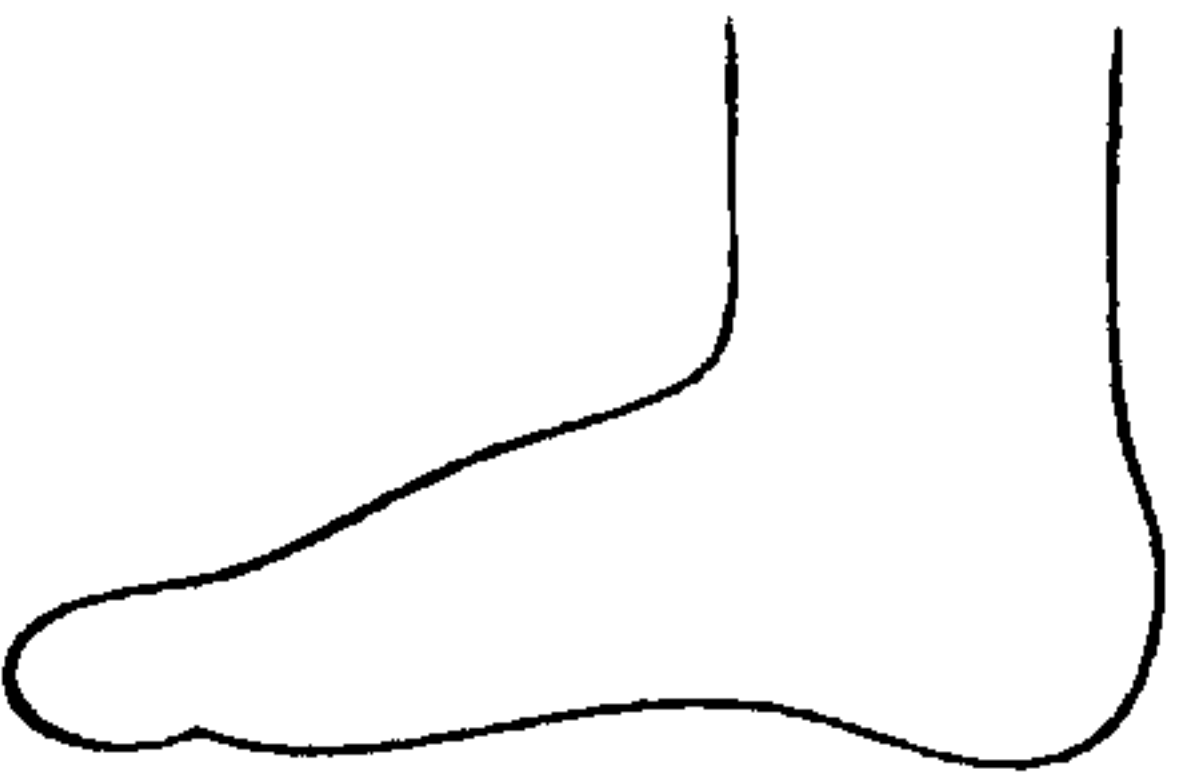

Outside of Foot

RIGHT FOOT



Bottom of Foot

Top of Foot



Outside of Foot

Inside of Foot

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since the time your pain or problem began, has it: ☐ Stayed the same ☐ Become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily Activities

☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe

☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

What treatment have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ Yes (Describe) _____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print name of patient, parent or guardian

Signature of doctor

If other than patient, relationship to patient

Date

Signature

Date