SUMMIT PODIATRY

PATIENT INFORMATION

Patient's Last Name	First		MI
Date of Birth	☐ Male ☐ Female	Social Security Number	Marital Status
Street Address	City	State	Zip Code

Home Phone	Cell Phone	Patient Email Address	
Emergency Contact Name	Relationship	Emergency Phone Number	
Patient's Occupation	Patient's Employer	Employer's Street Address	
City	State	Zip Code	Work Phone
Type of Insurance:		Policy Number	Group Number
Is policy holder the patient? ☐ Yes ☐ No If Not, Name of Policy Holder?		DOB of Policy Holder	Relationship ☐ Spouse ☐ Parent ☐ Other
		Policy holder's SSN	☐ Male ☐ Female

HOW DID YOU HEAR ABOUT US?

	Doctor's Office / Clinic: _____ Family / Friend: _____

MEDICAL HISTORY

Primary Doctor:		Date Last Seen	Pharmacy & City
Shoe Size	Height	Weight	Smoke ☐ No ☐ Yes _____Packs / Day ☐ Ex-Smoker, How Long _____, Quit ___ Years Ago
Alcohol ☐ No ☐ Yes: ____ per _____			I Use or Have Used Illicit Drugs? Type: _____ ☐ No ☐ Yes ☐ History of Use

FAMILY MEDICAL HISTORY

☐ Heart Disease Mother__ Father__ ☐ High Blood Pressure Mother__ Father__ ☐ Diabetes Mother__ Father__ ☐ Cancer Mother__ Father__ ☐ Cholesterol Mother__ Father__
☐ Other:

YOUR MEDICAL HISTORY

Diabetes: Type 1 or 2
☐ Insulin
☐ Non-Insulin
Last Blood Glucose: _____ mg/dl
Last Hg A1c: _____%
When? _____
Who manages your diabetes?
_____

History of Amputation?
☐ No ☐ Yes, Where?

- ☐ Acid Reflux
- ☐ Foot/Leg Ulcer
- ☐ Anemia
- ☐ Gout
- ☐ Arthritis (☐Osteo/☐Rheum)
- ☐ Heart Disease / Attack
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Back Problem: _____
- ☐ High Cholesterol
- ☐ Blood Clot / DVT
- ☐ Hormone Therapy

- ☐ Cellulitis / Skin Infection / ☐ MRSA
- ☐ Dementia/Alzheimer's
- ☐ Excessive/Easy Bleeding
- ☐ Fibromyalgia
- ☐ Kidney Disease (☐ dialysis)
- ☐ Liver Disease (☐Hepatitis __)
- ☐ Lung Condition: _____
- ☐ Mitral Valve Prolapse/Murmur
- ☐ Multiple Sclerosis
- ☐ Nervous Disorder/Depression
- ☐ Neuropathy
- ☐ Osteomyelitis
- ☐ Parkinson's Disease
- ☐ Cancer: _____
- ☐ Immune Disorder / HIV

- ☐ Previous Addiction to _____
- ☐ Pulmonary Embolism
- ☐ Rashes/ Skin Condition
- ☐ Raynaud's Disease/Phenom
- ☐ Seizure Disorder
- ☐ Sleep Apnea (☐ on CPAP?)
- ☐ Stroke ☐ RT ☐ LT (Year ___)
- ☐ Thyroid Condition (☐Hi ☐Lo)
- ☐ Varicose Veins
- ☐ Other:

Please Complete Back Portion Now →

In the Last Six Months?	□ Leg Cramps □ Cough □ Heart Attack □ Chest Pain □ Masses □ Wounds □Weight Loss/Gain □ Blurred Vision □ Palpitations □ Stroke □ Gout Attack □ Headache □ Shortness of Breath □ Rashes □ Fall □ Major Trauma
Allergies & Reactions	□ None Known □ Iodine □ Anti-Inflammatories □ Adhesive / Tape □ Latex □ Other: _____ □ Aspirin □ Local Anesthetic _____ □ Codeine □ Seafood/Shellfish _____ □ Cortisone □ Sulfa Drugs _____

Medication Name	Dose	Medication Name	Dose

Surgical History- Please List Any Surgeries You Have Had, Include Dates and Surgeon's Name If Possible

What Brings You In Today?

Describe your problem:

□ Left Foot □ Right Foot □ Left Ankle □ Right Ankle □ Both Feet □ Both Ankles

When did the problem begin? _____ Is this problem work related?: □ No □ Yes

Is this Related to an Injury? □ No □ Yes, Describe:_____ Date of Injury: _____

Pain Scale: **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
(circle) ***Minimal*** ***Moderate*** ***Severe*** ***Intolerable***

How Would You Describe the Pain?: _____

The Problem is: □ Improving □ Worsening □ Unchanged It Occurs When: _____

What Aggravates the Problem? _____What Improves the Problem? _____

Have Any Tests Been Done? □ X-Rays □ CT Scan □ MRI □ Labs □ None Where? _____

Previous medical treatment(s): _____

Have you Had Any Stents or Peripheral Vascular Surgery? □ No □ Yes When/ Surgeon? _____

Types of Activities You Enjoy/Engage in:_____

On average, how many hours a day do you stand? _____ How many hours a day do you sit? _____

Anything Else to Add: _____