Podiatry Associates
of
Beaufort/Bluffton

NEW/ESTABLISHED PATIENT FORM

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Last Office Visit: _____

Pharmacy (Name and Location) : _____

Please describe your foot problem (Include date of injury if applicable)

_____

_____

PERSONAL MEDICAL HISTORY

Check those that apply

	Frequent Headache / Migraines		Anemia / Blood Disorders
	Rheumatic Fever		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy / Seizures
	Diabetes Average Blood Sugar:		Prolonged Bleeding Time
	Tuberculosis		Stomach Disorder / Ulcer
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems / Tension
	Blood Clots		Asthma / Hay Fever / Shortness of Breath
	Tumor / Abnormal Growth / Cancer		Prostate Disorder
	Ear, Nose, Throat Disorder		Sexually Transmitted Disease

Has any family member had any of the following (please indicate relationship)

Cancer: _____ Diabetes: _____ Heart Trouble: _____

High Blood Pressure: _____ Kidney Disease: _____ Stroke: _____

Mental or Emotional Disease: _____ Tuberculosis: _____

Arthritis: _____ Emphysema: _____ Blood Clots: _____

PATIENT INFORMATION

Do you currently smoke? ___Yes ___No How many packs per day? _____ How many years? _____

Did smoke previously? ___Yes ___No How many packs/day? _____ How many years? _____ Year quit: _____

Amount of alcohol consumed per week _____

Please complete the following:

Height: _____ Weight: _____ Shoe Size: _____ Occupation: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Other____

Ethnicity: Please answer the following questions as it pertains to ETHNICITY. These questions are part of a federal requirement that we are required to meet. If you choose not to answer these questions please indicate here: [ ] I DECLINE

Race: [ ] CAUCASIAN [ ] AFRICAN AMERICAN [ ] AMERICAN INDIAN [ ] ASIAN[ ] HISPANIC/LATINO/SPANISH ORIGIN [ ] OTHER _____ please specify

ALLERGIES

Please check all allergies:

_____No Known Drug Allergies

_____Medications: _____

_____Foods: _____

_____Tapes _____Novocain _____Anesthetics _____Silver/Nickel/Costume Jewelry _____Other: _____

What types or reactions have you experienced? _____

_____

MEDICATIONS

Please list all prescription and over-the-counter medications and the dosages: _____

_____

_____

_____

_____

SURGICAL HISTORY

Surgical Procedures / Serious Injuries / Illnesses	Year	Physician

HEALTH REVIEW

Please circle any symptoms you have had in the past 3 months.	
General	Fever Chills Fatigue Weight Loss Weight Gain
Head	Headaches Visual Problems Hearing Problems Light Sensitivity
Cardiovascular	Chest Pain Palpitations Dizziness Swelling of Legs Other
Hematology	Anemia Abnormal bleeding/bruising Blood Clots Other Blood Disorder
Respiratory	Persistent Cough Wheezing Shortness of Breath
Gastrointestinal	Difficulty swallowing Indigestion/Heartburn Abdominal Pain Change in Bowel Habits
Urinary	Painful urination Frequent Nighttime Urination Bladder leakage Other
Musculoskeletal	Joint Pain/Swelling/Stiffness Back Pain Arthritis Muscle Weakness
Skin	Skin Rash Suspicious Lesions Itching
Neurological	Numbness of hands/feet Seizures Tremors Paralysis
Psychiatric	Depression Anxiety Problems Sleeping Memory Loss
Endocrine	Heat/Cold Intolerance Hot Flashes Change in hair/skin texture Other

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

Patient Signature: _____ Date: _____