THE CENTER FOR PODIATRIC CARE AND SPORTS MEDICINE

PATIENT INFORMATION SHEET:

PLEASE COMPLETE ALL THE QUESTIONS ON THE FORM

PATIENT'S NAME: ______________________________ AGE: ________ DATE OF BIRTH: __________________

ADDRESS: ____ CITY, ST., ZIP CODE___________________________

EMAIL: __________________________________ SEX: □ M □ F □ Unspecified

HOME PHONE: ____________________________________ CELL PHONE: _____________________________________

PRIMARY CARE PHYSICIAN: ___________________________________ PHONE: ______________________________

ADDRESS: ____

OCCUPATION: ____ EMPLOYER: ______________________________

INSURANCE COMPANY ___________________ PHONE: _______________ ARE YOU PRIMARY INSURED: □ YES □ NO

IF NO: PRIMARY INSURED _______________________DATE OF BIRTH: _________________

HOW WERE YOU REFERRED HERE: ____

EMERGENCY CONTACT: ______________________________ RELATIONSHIP: _______________________________

ADDRESS: ____ PHONE: _______________________________

1.What sports/activities do you participate in:

□ Running □ Cycling □ Soccer □ Football
□ Marathons □ Triathlons □ Basketball □ Swimming
□ Gymnastics □ Rowing □ Dance □ Cross fit
□ Tennis □ Golf □ Yoga □ Kickboxing
□ Walking □ Other________________________

2. Are you allergic or sensitive to any antibiotics or medications? ☐ Yes ☐ No

If so, which medications? ☐ Novacaine ☐ Aspirin ☐ Codeine
☐ Penicillin ☐ Cortisone ☐ Betadine
☐ Sulfa ☐ Erythromycin ☐ Adhesive Tape
Other ____

3. Are you taking any medications at this time? ☐Yes ☐No

If so, please list **name and dosage** ____

____

4. Do you or have you ever had any of the following?

□ Diabetes □ Phlebitis □ Bleeding problems □ Asthma
□ Arthritis □ Stroke □ High Blood Pressure □ Heart problems
□ Anemia □ Stomach problems □ Tuberculosis □ Liver Trouble
□ Emotional problems □ Emphysema □ Gout □ Thyroid problems
□ Kidney problems □ Cancer □ Broken Bones □ Numbness/Cramps
□ Epilepsy □ Hepatitis □ Rheumatic Disease □ HIV
□ High Cholesterol □ Ulcers □ Venereal Disease □ Blood Disorder

Any other health problems? ____

5. Have you undergone surgery? ☐ Yes ☐ No

If yes, what kind and when? ____

6. ***For Women***: Are you pregnant? ☐ Yes ☐ No

7. Chief complaint that brought you in today? ____

____

PATIENT SIGNATURE: ____ DATE: _____________________

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PATIENT INFORMATION SHEET PART 2

PLEASE COMPLETE ALL THE QUESTIONS ON THE FORM

PATIENT'S NAME: ____

HEIGHT: ____FT______INCHES SHOE SIZE: ____________

WEIGHT: _______________

PHARMACY NAME: ____

ADDRESS/PHONE: ____

FAMILY HISTORY (Parents and Siblings)

___ DIABETES ___ HIGH BLOOD PRESSURE ___ HEART DISEASE ___ ARTHRITIS

___ STROKE ___ HIGH CHOLESTEROL ___ CANCER

SMOKING (please check one)

___ CURRENT EVERYDAY SMOKER

___ CURRENT OCCASIONAL SMOKER

___ FORMER SMOKER

___ NEVER SMOKED

ALCOHOL INTAKE (please check one)

___ OVER 8 DRINKS/WEEK

___ 4-7 DRINKS/WEEK

___ 1-3 DRINKS/WEEK

___ NO ALCOHOL

RACE (please check)

___ NOT SPECIFIED

___ AMERICAN INDIAN OR ALASKA NATIVE

___ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

___ ASIAN

___ AFRICAN AMERICAN

___ CAUCASIAN

___ OTHER

ETHNICITY (please check)

___ NOT SPECIFIED

___ HISPANIC OR LATINO

___ NOT HISPANIC OR LATINO

PRIMARY LANGUAGE SPOKEN: ____