Name:____ Date of Birth:_______________ Age:_______

Address:____

Street Apt# City State Zip

Sex: MALE FEMALE Status: Married Single Widowed Other

Language:_____________________________________

Ethnicity/Nationality:___________________________________

Phone: Home ( )______________________________ Work ( )_________________________________

Cell ( )_______________________________________

Email:____

Employer:____ Occupation: ____________________________________

Emergency Contact:

Name:____ Relationship: _________________________

Phone: Home ( )______________________________ Work ( )_________________________________

Cell ( )____

Responsible Party/Primary Insurance Company Name:____

Name of Insured:_______________________________________ Date of Birth:___________ Relationship:___________

ID#:____ Group#:____

Employer:____ Employer Phone: ( )_________________________

Secondary Insurance Company Name:____

Name of Insured:_______________________________________ Date of Birth:___________ Relationship:___________

ID#:____ Group#:____

Employer:____ Employer Phone: ( )_________________________

What is the reason for you visit today? ____

____

How were you referred to our office?____

____

I certify that the information given above is true ad correct. I understand that it is my responsibility to notify West Hartford Podiatry Associates of any changes to the above information.

Patient or Guardian Signature:____

Date:___________________________

History & Medical Information

1. Primary Care Physician:____
Phone Number: (   )______________________________ Date of Last Visit:_________________________________
2. Explain your foot/ankle problem:____
3. When did the pain/discomfort begin? (date):____
Describe the pain/discomfort: Burning Numbness Sharp Other:______________
4. What makes the pain/discomfort better?____
5. What makes the pain/discomfort worse?____
6. Has the condition been treated? YES NO When and How?:_________________________

7. Past Medical History:

Anemia	Gout	Kidney Disease	Other Arthritis
Bleeding Disorders	Heart Disease	Lung Disorders	Prostate Disorders
Cancer	Hepatitis	Mitral Valve Prolapse	Rheumatic Fever
Diabetes	High Cholesterol	Nerve Disorders	Thyroid Disorders
Epilepsy	HIV/Aids	Neurologic	Stroke
	High Blood Pressure	Osteoarthritis	Other:__________________

8. List all Medications/herbs/vitamins: None

____

____

What is your Pharmacy's name?___________________________________ Phone #:(   )________________________
9. Allergies: NONE

Penicillin	Aspirin	Shellfish
Narcotic Agent/Codeine	Anesthesia	Other:___________________________
Sulfa Drugs	Radiographic Contrast/Dyes	

10. Surgical History:
Have you had surgery? YES NO
Describe (surgery/date):____

11. Social History:

Tobacco Use	Alcohol Use	Exercise Habits__________	If yes, how much?________
		_______________________	_______________________
Caffeine Use	Drug Use (recreational, IV)	Pregnant	Nursing

12. Occupation/Job:____

13. Family History (List relationship of member(s) who have had problems):

Diabetes	Heart Disease	Bleeding Disorders	Mental Illness
High Blood Pressure	Stroke	Kidney Disease	Cancer
Rheumatology	Other Family History:____		