New Patient Form

Armstrong Podiatry

Keeping Feet in *Motion*

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Last Visit w/PCP: _____

Endocrinologist: _____Last Visit w/Endo: _____Referred By: _____

Please describe your problem (include date of injury if applicable): _____

_____

_____

_____

PAST MEDICAL HISTORY

Check all that apply:

	Frequent Headache/Migraine		Anemia / Blood Disorders
	Rheumatic Fever		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis MWF or T TH Sa		Epilepsy / Seizures
	Diabetes Average Blood Sugar:		Prolonged Bleeding Time
	Tuberculosis		Stomach Disorder
	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 problems (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? ____ No ___ Yes If yes, how many packs /day? _____ How many years? _____

Smoke previously? ____ No ___ Yes If yes, how many packs/day? _____ How many years? ____ Year Quit: _____

Number of caffeine drinks per day: _____ Amount of alcohol consumed per week? _____

Please complete the following:

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

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Other:_____

Exercise Type/Duration/ Frequency (Example: Walk 10 minutes 3X per week):_____

_____

ALLERGIES

Please check all allergies:

___Medications: _____

___Foods: _____

___Tapes ___Novocain ___Anesthetics ___Silver/Nickel/Costume Jewelry ___Other:_____

What types of 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	Hospital

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 Night-time Urination Bladder Leakage Other
Musculoskeletal	Join 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 her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of infections as necessary.

Patient Signature: _____ Date: _____

I have personally reviewed the above information:

Physician Signature: _____ Date: _____