westhartfordpodiatry.net

Demographic Form

West Hartford Podiatry

Name *

Date of Birth:

Age:

Address:

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 your visit today?

How were you referred to our office?

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

By typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.

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?

Describe the pain/discomfort:

Describe the pain/discomfort:

Burning **Numbness** **Sharp** **Other**

If Other, Please specify:

4. What makes the pain/discomfort better?

5. What makes the pain/discomfort worse?

6. Has the condition been treated? **When:** **How:**

Yes **No**

7. Past Medical History:

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

If Other, Please Specify:

8. List all Medications/herbs/vitamins:

What is your Pharmacy's name?

9. Allergies

NONE	Sulfa Drugs	Radiographic Contrast/Dyes
Penicilin	Aspirin	Shellfish
Narcotic Agent/Codeine	Anethesia	Other

If Other, Please Specify.

10. Surgical History:

Have you had surgery? **Describe (Surgery/Date):**

Yes **No**

11. Social History

Tobacco Use	Alcohol Use
Caffeine Use	Drug Use (Recreational, IV)

Exercise Habits **if Yes, How much?**

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	

If Other Family History, Please Specify