westhartfordpodiatry.net

Patient Information 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?

☐ **Yes** ☐ **No**

When:

How:

7. Past Medical History:

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

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?

- [ ] **Yes**
- [ ] **No**

Describe (Surgery/Date):

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