Patient Name:			DOB:	Today's Date:
Street Address:			Email:	
City:	State:	Zip:	Sex: ☐ Male ☐ Female ☐ Decline	
Phone:	Mobile Phone:		Height:	Weight:
Patient SS#:	PCP:		Pharmacy:	
Shoe Size:	Shoe Width:	Are you Pregnant? ☐ Yes ☐ No ☐ DNA		
Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		Number of children:	Flu Shot: ☐ Yes ☐ No	
Emergency Contact:		Phone:	Relationship:	
How did you hear about us? ☐ Google ☐ PCP ☐ Insurance Co. ☐ Social Media ☐ Yellow Pages ☐ Friend:				

Insurance Information

Please allow our office to make a copy of your insurance cards

Primary Insurance Co.	ID #:	
Subscriber's Name:	Group #:	
Subscriber's SS#:	DOB:	Relation:
Secondary Insurance Co.	ID #:	
Subscriber's Name:	Group #:	
Subscriber's SS#:	DOB:	Relation:

Medications & Allergies

Check all that apply and/or fill in the blanks

List your allergies: _____

☐ None ☐ Latex ☐ Penicillin ☐ Lidocaine ☐ Novocaine ☐ Sulfa ☐ Tape ☐ IVP Dye ☐ Codeine ☐ Aspirin

What medications do you take? ☐ None ☐ I have brought a list

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

Current Problem

What is the reason for your visit today?

Where is the pain/problem?	Prevent you from working? ☐ Yes ☐ No
When did the pain/problem start?	Does it hurt with shoes on? ☐ Yes ☐ No
Did the pain/problem: ☐ Begin suddenly ☐ Develop gradually	Does it hurt Barefoot? ☐ Yes ☐ No

Since the pain began, has it: ☐ Stayed the same ☐ Become worse ☐ Improved

How would you describe the pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Itching ☐ Throbbing ☐ Other:	If this was an injury, please describe:

On a scale from 0 to 10, rate your pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

What makes the pain/problem feel better?

What makes the pain/problem feel worse?

What have you done to treat the condition?

If you are over 65, fill out this section:

Do you have an advanced directive? ☐ Yes ☐ No	What type? ☐ Living Will ☐ Power of Attorney
Any falls in last 12 months? ☐ Yes ☐ No	Pneumococcal Vaccine: ☐ Yes ☐ No

Do you use any device to help you walk? ☐ Cane ☐ Walker ☐ None	*Continue on back >>*

Check all that apply and/or fill in the blanks

Are you Diabetic? ☐ Yes ☐ No	☐ Type I ☐ Type II	How long have you been diabetic?
Average blood Sugar range?	What is your HbA1c?	Currently taking: ☐ Pills ☐ Insulin

Past Medical Problems

Circle all that apply

HEENT

Cataracts	Glaucoma	Migraines	Headaches	

Cardiovascular

Angina	Abnormal beat	High blood pressure	Blood clots	Circulation Problem
Coronary dx	Pacemake	High Cholesterol	Phlebitis	Cold Feet
Heart Attack	Mitral valve prolapse	Anemia	Deep Vein Thrombosis	Blood Transfusion?
Congestive heart dx	Heart valve disease	Leukemia	Bleeding disease	Yes No

Endorine/GI/GU

Hypothyroidism	GERD	Stomach Ulcer	Hiatal Hernia	Prostate
Hyperthyroidism	Irritable Bowel	Hepatitis	Kidney Disease	Dialysis
Incontinence		Gall Bladder	Liver Disease	

Respiratory

Asthma	COPD	Bronchitis	Sleep Apnea	Do you use Oxygen?
Tuberculosis	Emphysema	Pneumonia		Yes No

Neurological

Depressio /Anxiety	Bipolar	Multiple Sclerosis	Seizures	Cerebral Palsy
Stroke	Dementia	Down Syndrome	Alzheimer's	Mental disability

Musculoskeletal

Hip Prosthesis	Low back pain	Osteoarthritis	Osteoporosis	Fibromyalgia
Knee Prosthesis	Other Implants	Amputation	Rheumatoid Dx	

Hospitalizations/Surgeries

Reason _____ Reason _____ Reason _____

Date _____ Date _____ Date _____

Family History

List your family history:

Social History

Check all that apply and/or fill in the blanks

Smoking Status: ☐ Never ☐ Former- When did you quit? _____ ☐ Smoke ____ packs per day for ____ years		
Sight Impaired? ☐ Yes ☐ No	Hearing Impaired? ☐ Yes ☐ No	Handicapped? ☐ Yes ☐ No

Work Status: ☐ Unemployed ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Student ☐ Retired

How often are you on your feet at work? ☐10% ☐25% ☐50% ☐75% ☐100%

How often do you exercise? ☐Never ☐ Rarely ☐Weekly ☐ Several times per week ☐ Daily

Tell us about a typical work day: _____

Tell us about your daily activities: _____

Your signature verifies that the medical information that has been provided above is accurate to the best of your knowledge. Further, your signature acknowledges that Laurel Podiatry Associates, LLC has given you the opportunity to read the HIPAA privacy policies, practices and procedures that are used in this office and required by federal law. It is understood that a separate consent is needed for disclosure of your private health information.It is also understood that by seeking foot care to be provided by this office, that you give consent for those examinations and/or treatments that are commonly performed in this office. This includes, but is not limited to, treatment for toenail and skin conditions, circulation problems, neurological problems, and deformations of the foot. This may include surgical procedures, x-rays, vascular tests, gait analysis or injections.

Signature: _____ Date: _____

Updated: 02/2020