LAKE PODIATRY NEW PATIENT / CONSULTATION FORM

Date _____ Social Security #: _____

E-Mail: _____

Birthdate: _____ Male ☐ Female ☐

Name: _____ _____ _____
First MI Last

Address: _____
Mailing City State Zip

Phone: _____ _____ _____
Home Cell Work

Which is your preferred communication method: HOME CELL EMAIL

Nickname / I like to be called: _____

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Decline to Specify

Race: American Indian / Asian / Black or African American / Decline to Specify / Native Hawaiian or Pacific Islander / White

Your Occupation: _____ Your Employer: _____

Married (if yes # of years_____) Single Divorced Widowed Other

Name of Your Spouse/Significant other: _____

_____ _____
Primary Care Physician Referred by

_____ _____ _____
Insurance Company Policy Number Subscriber

_____ _____ _____
Insurance Company Policy Number Subscriber

_____ _____
Person responsible for payment Address (if different from above)

_____ _____
Birthdate Social Security #

_____ _____
In case of an emergency, notify Phone number

_____ _____
Address (if different from above) Relationship

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Current medications with dosage and regimen (including OTC and Supplements:

Allergies:

- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Local anasthetics
- ☐ Iodine
- ☐ Shellfish
- ☐ Latex
- ☐ Tape
- ☐ Non-Steroidal medications
- ☐ General anasthetics
- ☐ Other: _____
- ☐ _____

Previous Injuries:

Previous Surgeries:

Previous Hospitalizations:

Family Health History:

Mother _____ Other _____

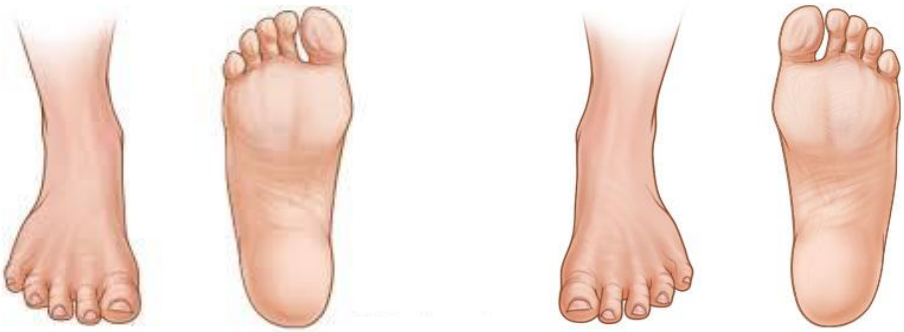
Father _____ _____

Siblings _____ _____

Children _____ _____

PLEASE USE CIRCLES AND ARROWS TO INDICATE PAINFUL, INJURED OR PROBLEM AREA(S)

Right



Left

IN YOUR OWN WORDS WHAT ARE YOU BEING SEEN FOR TODAY?:

Height: _____ Weight: _____

Office Use Only:

BP: _____ P: _____ R:_____ Temp: _____ O2: _____

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Are you taking any of the following:

- ☐ Echinacea
- ☐ Garlic
- ☐ Ginger
- ☐ Ginko Biloba
- ☐ St. John's Wort
- ☐ Ginseng
- ☐ Kava Kava
- ☐ Feverfew
- ☐ Ephedra
- ☐ None of the Above

Immunizations Current:

- ☐ Polio (OPV or IPV)
- ☐ DPT/DTaP
- ☐ Measles
- ☐ MMR
- ☐ Hep B (3 doses)
- ☐ Varicella
- ☐ Unknown

Tetanus Status:

- ☐ Current
- ☐ Over 5 years
- ☐ Over 10 years
- ☐ Unknown

Please check all that you currently have or that you have had in the past:

Major Diseases:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Angina
- ☐ Arrhythmia
- ☐ Murmur
- ☐ Stroke
- ☐ Chest Pain
- ☐ Mitral Valve Prolapse
- ☐ Cancer

Respiratory:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent Colds
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Emphysema

MISC:

- ☐ Epilepsy
- ☐ Thyroid Disease
- ☐ Muscle Disease
- ☐ Kidney Disease
- ☐ Bladder Problems
- ☐ Prostate Problems
- ☐ Venereal Disease
- ☐ Skin Conditions
- ☐ Hepatitis
- ☐ Cancer History

HEENT:

- ☐ Migraines
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Eye Problems
  - a) Glasses
  - b) Glaucoma
  - c) Cataracts
  - d) Macular Degeneration

Vascular:

- ☐ Anemia
- ☐ Sickle Cell
- ☐ Bleeding Disorder
- ☐ Poor Circulation
- ☐ Night Cramps
- ☐ Leg Pain when walking
- ☐ Vein issues
- ☐ Swelling Phlebitis
- ☐ Leg Ulcer(s)
- ☐ Blood Clot(s)
- ☐ Transfusions

Gastrointestinal:

- ☐ Ulcers
- ☐ Bowel Disorder(s)
- ☐ Stomach Problem(s)
- ☐ Hiatal Hernia
- ☐ GI or Rectal Bleeding
- ☐ Acid Reflux (GERD)

Psychological:

- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric Condition(s)
- ☐ Drug Dependence
- ☐ Alcohol Dependence

Arthritis:

- ☐ Osteoarthritis
- ☐ Rheumatoid
- ☐ Gout
- ☐ Sero-negative
  - a) Reiters
  - b) PsA
  - c) Anklyosing
  - d) Spondylitis
  - e) CCPD
  - f) IBS

Other:

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Name: _____ Date: _____

1.) Shoe size:

2.) Left or Right handed:

3.) Tobacco use: Current: YES / NO / Never Past: YES / NO / Never

If Yes, how many years and how many packs per day?

_____

4.) Are you exposed to second hand smoke on a regular basis?: YES / NO

5.) Do you wear your seatbelt?: YES / NO

6.) Do you use recreational drugs?: YES / NO

7.) Are smoke detectors installed and maintained in your home?: YES / NO

8.) Are carbon monoxide detectors installed and maintained in your home?: YES / NO

9.) Are you receiving home health care services? YES / NO or Hospice? YES / NO

10.) Do you have any personal, religious or personal beliefs that you would like included in your care?

YES / NO _____

11.) Do you have an advanced care plan such as Power of Attorney and/or living will?: YES / NO

12.) Did you get your flu shot?: YES / NO When: _____

Did you get your pneumonia shot?: YES / NO When: _____

13.) Have you fallen in the last three months?: YES / NO

14.) Do you feel abused or neglected?: YES / NO

15.) Do you feel you are getting adequate food from all the major food groups?: YES / NO

16.) Do you own a gun or are there guns in the home?: YES / NO

If yes, are they locked and stored safely? YES / NO

17.) Do you feel safe at home?: YES / NO

18.) Do you drink coffee?: YES / NO How many cups/oz. per day/week?: _____

19.) Do you drink tea?: YES / NO How many cups/oz. per day/week ?: _____

20.) Do you drink alcohol?: YES / NO How often & amount?: _____ per Day/ Week/ Year

21.) Do you have any pets?: YES / NO How many and what variety?: _____

_____