

LAKE PODIATRY NEW PATIENT / CONSULTATION FORM

Date _____ Social Security #: _____

E-Mail: _____

Age: _____ 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 _____

1. Insurance Co _____ Policy Number _____ Subscriber _____

2. Insurance Co _____ Policy Number _____ Subscriber _____

3. Insurance Co _____ Policy Number _____ Subscriber _____

PERSON RESPONSIBLE FOR PAYMENT ADDRESS (if different from above)

Date of Birth _____ 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:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Non-Steroidal medications |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Shellfish | <input type="checkbox"/> General anesthetics |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Tape | <input type="checkbox"/> _____ |

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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<p>Are you taking any of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Echinacea <input type="checkbox"/> Garlic <input type="checkbox"/> Ginger <input type="checkbox"/> Ginko Biloba <input type="checkbox"/> St. John's Wort <input type="checkbox"/> Ginseng <input type="checkbox"/> Kava Kava <input type="checkbox"/> Feverfew <input type="checkbox"/> Ephedra <input type="checkbox"/> None of the Above 	<p>Immunizations Current:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Polio (OPV or IPV) <input type="checkbox"/> DPT/DTaP <input type="checkbox"/> Measles <input type="checkbox"/> MMR <input type="checkbox"/> Hep B (3 doses) <input type="checkbox"/> Varicella <input type="checkbox"/> Unknown 	<p>Tetanus Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current <input type="checkbox"/> Over 5 years <input type="checkbox"/> Over 10 years <input type="checkbox"/> Unknown
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Please check all that you currently have or that you have had in the past:

<p>Major Diseases:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Angina <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Murmur <input type="checkbox"/> Stroke <input type="checkbox"/> Chest Pain <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Cancer 	<p>Respiratory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Lung Disease <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Emphysema 	<p>MISC:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Muscle Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Bladder Problems <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Skin Conditions <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cancer History 	<p>HEENT:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Eye Problems <ul style="list-style-type: none"> a) Glasses b) Glaucoma c) Cataracts d) Macular Degeneration
<p>Vascular:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Night Cramps <input type="checkbox"/> Leg Pain when walking <input type="checkbox"/> Vein issues <input type="checkbox"/> Swelling Phlebitis <input type="checkbox"/> Leg Ulcer(s) <input type="checkbox"/> Blood Clot(s) <input type="checkbox"/> Transfusions 	<p>Gastrointestinal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ulcers <input type="checkbox"/> Bowel Disorder(s) <input type="checkbox"/> Stomach Problem(s) <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> GI or Rectal Bleeding <input type="checkbox"/> Acid Reflux (GERD) 	<p>Psychological:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Psychiatric Condition(s) <input type="checkbox"/> Drug Dependence <input type="checkbox"/> Alcohol Dependence 	<p>Arthritis:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Gout <input type="checkbox"/> Sero-negative <ul style="list-style-type: none"> 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.) Education level: _____
 - 4.) Tobacco use: Current: YES / NO / Never Past: YES / NO / Never
If Yes, how many years and how many packs per day?

 - 5.) Are you exposed to second hand smoke on a regular basis?: YES / NO
 - 6.) Do you wear your seatbelt?: YES / NO
 - 7.) Do you use recreational drugs?: YES / NO
 - 8.) Are smoke detectors installed and maintained in your home?: YES / NO
 - 9.) Are carbon monoxide detectors installed and maintained in your home?: YES / NO
 - 10.) Are you receiving home health care services? YES / NO or Hospice? YES / NO
 - 11.) Do you have any personal or religious beliefs that you would like included in your care?
YES / NO _____
 - 12.) Do you have an advanced care plan such as Power of Attorney and/or living will?: YES / NO
 - 13.) Did you get your flu shot?: YES / NO When: _____
Did you get your pneumonia shot?: YES / NO When: _____
 - 14.) Have you fallen in the last three months?: YES / NO
 - 15.) Do you feel abused or neglected?: YES / NO
 - 16.) Do you feel you are getting adequate food from all the major food groups?: YES / NO
 - 17.) Do you own a gun or are there guns in the home?: YES / NO
If yes, are they locked and stored safely? YES / NO
 - 18.) Do you feel safe at home?: YES / NO
 - 19.) Do you drink coffee?: YES / NO How many cups/oz. per day/week?: _____
 - 20.) Do you drink tea?: YES / NO How many cups/oz. per day/week?: _____
 - 21.) Do you drink alcohol?: YES / NO How often & amount?: _____ per Day/ Week/ Year
 - 22.) Do you have any pets?: YES / NO How many and what variety?: _____
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