DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ AGE: _____ SEX: M F

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (___) ____-_____ CELL PHONE #: (___) ____-_____ E-MAIL- _____

PRIMARY CARE DOCTOR NAME:_____

PHONE/ADDRESS: _____

PRIMARY LANGUAGE:_____ ETHNICITY:_____

PHARMACY: _____ LOCATION: _____ __PHONE #: (___) ____-_____

INSURANCE INFORMATION

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ____-_____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ____-_____

CONTRACT # _____ GROUP # _____

PATIENT HISTORY

ALLERGIES: [ ] NONE KNOWN

[ ] MEDICATION ALLERGIES _____

[ ] ANESTHESIA ALLERGIES _____

[ ] FOOD ALLERGIES _____

OTHER_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE FREQUENCY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] **ABNORMAL BLEEDING** [ ] **CANCER** [ ] **LIVER DISEASE** [ ] **SKIN DISORDER**

[ ] **ACID REFLUX** [ ] **DIABETES** [ ] **LOW BLOOD PRESSURE** [ ] **SLEEP APNEA**

[ ] **ANEMIA** [ ] **FIBROMYALGIA** [ ] **MIGRAINE HEADACHES** [ ] **STOMACH ULCERS**

[ ] **ARTHRITIS** [ ] **GOUT** [ ] **MITRAL VALVE PROLAPSE** [ ] **STROKE**

[ ] **ASTHMA** [ ] **HEART ATTACK** [ ] **NEUROPATHY** [ ] **THYROID DISEASE**

[ ] **BACK TROUBLE** [ ] **HEART DISEASE/FAILURE** [ ] **OPEN SORES** [ ] **TUBERCULOSIS**

[ ] **BLADDER INFECTIONS** [ ] **HEPATITIS** [ ] **PNEUMONIA**

[ ] **BLOOD CLOTS** [ ] **HIV/AIDS** [ ] **POLIO**

[ ] **BLOOD TRANSFUSION** [ ] **HIGH BLOOD PRESSURE** [ ] **RHEUMATIC FEVER**

[ ] **BRONCHITIS/EMPHYSEMA** [ ] **KIDNEY DISEASE** [ ] **SICKLE CELL DISEASE**

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

_____

_____

SOCIAL HISTORY:

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

WEIGHT:_____ Height_____

IF YOU ARE DIBETIC:

Last fasting blood sugar_____ Last A1c Test_____ Shoe size:_____

FOR MEDICAL STAFF ONLY:

FOOT EXAM: [ ] TRUE [ ] FALSE **BLOOD PRESSURE:**_____