CAROLINA PODIATRY GROUP, INC – PATIENT INFORMATION

FIRST NAME ________________________________ M.I. _______ LAST NAME _____________________________

SSN# ______-______-______ DATE OF BIRTH _____/_____/_____ EMAIL: ____________________________________

MAILING ADDRESS: ____

____ _______________ ____________________________________
(CITY) (STATE) (ZIP CODE)

HOME PHONE: ____________________ WORK PHONE: ___________________ CELL PHONE: __________________

MAY WE LEAVE A MESSAGE AT THE ABOVE NUMBERS? Y or N WHO MAY WE SPEAK WITH CONCERNING YOUR MEDICAL CARE? ____

Is there a POA handling your medical affairs Y or N If so, Who? ____

FAMILY DOCTOR (PCP): ___________________________________ DATE LAST SEEN@PCP ____________________

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER: ___________________ GENDER: MALE FEMALE

RACE: WHITE BLACK/AFRICAN AMERICAN HISPANIC/LATINO OTHER: _____________________________

EMERGENCY CONTACT: ____ PHONE: _________________________

MARITAL STATUS: M D S W STUDENT STATUS: FULL-TIME PART-TIME NON-STUDENT

EMPLOYMENT STATUS: FULL-TIME PART-TIME UNEMPLOYED RETIRED

PLACE OF EMPLOYMENT: ____

JOB TITLE: ____ HOURS/DAY __________________________

INITIAL HEALTH HISTORY

(CONFIDENTIAL)

What is the reason for your visit today? (Circle All That Apply)

ANKLE PAIN	DERMATITIS (Rash)	FUNGAL NAILS	INGROWN NAILS	WART
BUNION	DIABETIC FOOT CARE	HAMMERTOES	ROUTINE FOOT CARE	OTHER
CORNS/CALLOUSES	FOOT PAIN	HEEL PAIN	ULCERS	

WHAT IS YOUR SHOE SIZE? __________ ALLERGIES: FOOD - __________________ INSECTS - ___________
DRUG ALLERGIES - ____

WHAT MEDICATIONS ARE YOU TAKING?

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

PHARMACY NAME: ____ PHONE: __________________________

PHARMACY ADDRESS: ____

____ _________________________

Signature of Patient or Legal Guardian **Date**

PAST MEDICAL HISTORY: CHECK ☑ CONDITIONS YOU **CURRENTLY** HAVE OR HAD IN THE PAST.

- AIDS/HIV Positive
- Alcoholism
- Alzheimer's
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Back Problems
- Bleeding Disorders
- Cancer: type ____
- Congestive Heart Failure
- COPD
- Drug Dependency
- Diabetes: type ___
- Emphysema
- Epilepsy/Seizures
- Fibromyalgia
- Glaucoma
- Gout
- Heart Disease/Attack
- Hepatitis: type ___
- Hernia
- Herpes
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Low Blood Pressure
- Mononucleosis
- Multiple Sclerosis
- Pace Maker/Defib.
- Pneumonia
- Polio
- Pregnancy
- Prostate Problems
- Stomach Ulcers
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Urinary Tract Infection
- Vascular Disease
- Other: _________

PAST SURGERIES: PLEASE LIST ALL SURGERIES THAT YOU HAVE HAD (NOT JUST FOOT RELATED):

____

____

FAMILY HISTORY: DOES ANYONE IN YOUR **IMMEDIATE** FAMILY HAVE ANY MAJOR MEDICAL PROBLEMS? IF SO, LIST WHO AND WHAT: ____

____

SOCIAL HISTORY: DO YOU DRINK ALCOHOL? **Y** or **N** IF **YES**, HOW OFTEN? ___________________________

DO YOU SMOKE OR USE TOBACCO? **Y** or **N** IF **YES**, # OF PACKS/DAY? _________ HOW LONG? ________YRS

IF YOU PREVIOUSLY SMOKED OR USED TOBACCO, HOW LONG SINCE YOU QUIT? ___________________________

DO YOU OR HAVE YOU EVER USED ILLEGAL DRUGS? **Y** or **N** DID YOU GET A FLU SHOT THIS YEAR? **Y** or **N**

REVIEW OF SYSTEMS: CHECK ☑ SYMPTOMS YOU **CURRENTLY** HAVE OR HAD IN THE **RECENT** PAST.

CONSTITUTIONAL

- DECREASED APPETITE
- CHILLS
- FEVER
- HEADACHE
- DIZZINESS
- CONVULSIONS
- DEHYDRATION
- FAINTNESS
- HOT FLASHES
- MIGRAINE
- NAUSEA/VOMITING
- NIGHT SWEATS
- SLEEP PROBLEMS
- TIREDNESS
- SUDDEN WEIGHT GAIN
- SUDDEN WEIGHT LOSS

CARDIOVASCULAR

- ANKLE SWELLING
- CALF CRAMPS
- TIGHTNESS IN CHEST
- COLD FEET/HANDS
- CRUSHING PAIN IN CHEST
- ELEVATED BLOOD PRESSURE
- HEART FLUTTERS
- NUMBNESS
- PAIN IN LEFT SHOULDER
- RACING HEARTBEAT
- SHORTNESS OF BREATH
- LEGS/FEET DISCOLORED OR BLUISH

ENDOCRINE

- INCREASED THIRST
- INCREASED HUNGER
- INCREASED URINATION
- BLEEDING GUMS

ENMT

- COUGHING UP BLOOD
- DRY COUGH
- COUGHING UP PHLEGM
- DIFFICULTY HEARING
- RINGING IN EARS
- STUFFY/RUNNY NOSE
- SINUS CONGESTION
- SORE THROAT

______________________________ ______________________

Signature of Patient or Legal Guardian **Date**

EYES

- BLURRED VISION
- CATARACTS
- CONTACTS
- DRY EYES
- GLASSES
- GLAUCOMA
- ITCHY EYES

GI

- ABDOMINAL CRAMPS
- BLOATING
- BLOOD IN STOOL
- BOWEL CHANGES
- CONSTIPATION
- DIARRHEA
- GAS
- HEARTBURN/ INDIGESTION
- HEMORRHOIDS
- NAUSEA
- RECTAL BLEEDING
- VOMITING

GU

- PAINFUL URINATION
- BLOOD IN URINE
- BURNING IN URINATION
- LACK OF BLADDER CONTROL
- FREQUENT URINATION AT NIGHT
- INCREASED URINATION

IMMUNOLOGIC

- ARTHRITIC FLARE-UP
- RECENT ASTHMA ATTACK
- EYES WATERING
- GOUTY ATTACK
- HAY FEVER
- HEPATITIS B CARRIER
- SEASONAL ALLERGIES
- SNEEZING

LYMPHATIC

- ANKLE SWELLING
- BLEEDING PROBLEMS
- BLOATING
- CALF PAIN
- FATIGUE
- FREQUENT NOSEBLEEDS
- RECENT NIGHT SWEATS
- WATER RETENTION

SKIN

- BLISTERS
- BRUISE EASILY
- BURNING OF SKIN
- DRY, SCALY SKIN
- ECZEMA
- HAIR LOSS
- HIVES
- ITCHY SKIN
- NON-HEALING WOUND
- RASH
- SUNBURN
- NAIL CHANGES

MUSCLE

- BACK PAIN
- DECREASED RANGE OF MOTION
- HEEL PAIN
- HIP PAIN
- SCARS
- JOINT SWELLING
- LEG CRAMPS
- MUSCLE TENDERNESS
- NECK PAIN
- WEAKNESS
- TINGLING SENSATION

NEUROLOGICAL

- NUMBNESS
- PARALYSIS
- RECENT SEIZURE
- TINGLING
- TREMORS
- UNCONTROLLED MOVEMENTS

PSYCHIATRIC

- ADDICTION TO ALCOHOL
- ATTEMPTED SUICIDE
- CLAUSTROPHOBIA
- DEPRESSION
- FORGETFULNESS
- INDUCED VOMITING
- IRRITABILITY
- PANIC ATTACKS
- PARANOIA
- SUICIDAL THOUGHTS
- ANXIETY

RESPIRATORY

- DIFFICULTY BREATHING
- CHEST TIGHTNESS
- COLD-LIKE SYMPTOMS
- PERSISTENT COUGHING
- COUGHING UP BLOOD
- COUGHING UP PHLEGM
- RECENT ASTHMA ATTACK
- SLEEP APNEA
- SHORTNESS OF BREATH
- WHEEZING

By signing below, you state that the information provided above is accurate to the best of your knowledge. You also understand that this information is being gathered for the purpose of treating your foot condition as it may be caused by or affected by other underlying medical conditions. We may also use this information to assist emergency personnel in treating you if a medical emergency should arise.

Signature of Patient or Legal Guardian **Date**