

# J. W. Podiatry, P.C.

Podiatric Medicine  
Foot Orthopedics and Surgery

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Date \_\_\_\_\_

## PATIENT INFORMATION SHEET

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Marital Status: \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ May we contact you at work?  Yes  No

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Pharmacy Used: \_\_\_\_\_ Phone: \_\_\_\_\_ Town: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I \_\_\_\_\_, understand that I am responsible for any, all or part of my account that is not paid by my insurance company.

I authorize the release of any medical information necessary to process claims.

I hereby give permission to administer treatment and to perform such procedures as may be deemed necessary in diagnosis and / or treatment of my foot condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Whom referred you to this office? \_\_\_\_\_

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**FAMILY HISTORY**

			CAUSE OF DEATH	IS THERE A FAMILY (BLOOD RELATIVE) HISTORY OF: (PLEASE CHECK)	
MOTHER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	_____	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> STROKE
FATHER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	_____	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> BUNIONS
BROTHER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	_____	<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> HAMMERTOES
SISTER	LIVING <input type="checkbox"/>	DECEASED <input type="checkbox"/>	_____	<input type="checkbox"/> NEUROLOGICAL DISORDER	<input type="checkbox"/> CIRCULATION PROBLEMS IN LEGS OR FEET
				<input type="checkbox"/> DIABETES	WHO?

**Review of Systems**

Do you currently have problems related to the following systems? Circle Yes or No.

**Please explain any Yes answers in space provided****Constitutional Symptoms**

Fever	Y	N
Chills	Y	N
Headache	Y	N
Unexplained Weight Loss	Y	N
Other _____		

**Eyes / Hearing**

Poor Vision	Y	N
Blind	Y	N
Hard of Hearing	Y	N
Other _____		

**Allergic / Immunologic**

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

**Neurological**

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other _____		

**Endocrine**

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Excessive Urination	Y	N
Other _____		

**Gastrointestinal**

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Jaundice	Y	N
Indigestion/heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N
Other _____		

**Cardiovascular**

Chest Pain	Y	N
Varicose Veins	Y	N
Phlebitis	Y	N
High Blood Pressure	Y	N
Claudication	Y	N
Ankle Swelling	Y	N
Other _____		

**Dermatology**

Skin Rash	Y	N
Moles	Y	N
Persistent Itch	Y	N
Other _____		

**Musculoskeletal**

Sciatica	Y	N
Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other _____		

**Respiratory**

Wheezing	Y	N
Shortness of Breath	Y	N
Other _____		

**Hematologic/Lymphatic**

Swollen Glands	Y	N
Blood Clotting Problem	Y	N
HIV/Hepatitis A, B, C	Y	N
Other _____		

**Psychologic**

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Other _____		

PHYSICIANS COMMENTS/NOTES:

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# Medical Information

This information is important for our records and your health

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DESCRIBE YOUR FOOT PROBLEM

HOW LONG HAS IT BEEN BOTHERING YOU?

WHAT MAKES IT FEEL BETTER?

WHAT MAKES IT FEEL WORSE?

ANY PAST PROBLEMS OF YOUR FEET AND ANKLES? DESCRIBE

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_

MEDICATIONS YOU ARE NOW TAKING: \_\_\_\_\_

## ALLERGIES

I HAVE NO ALLERGIES OR DRUG REACTIONS

I AM ALLERGIC TO OR HAVE A PROBLEM WITH THE FOLLOWING:

ASPIRIN

SULFA DRUGS

OTHERS: \_\_\_\_\_

NOVACAIN/LOCAL ANESTHETICS

IODINE

CODEINE

ADHESIVE TAPE

NARCOTICS (PERCOCET)

LATEX

PENICILLIN

ANTIBIOTICS (KEFLEX, ERYTHROMYCIN)

DO YOU HAVE DIABETES?

IF YES, DO YOU TAKE INSULIN?

HAVE YOU HAD ANY SERIOUS ILLNESSES? HOSPITALIZATIONS?

YES  NO

YES  NO  \_\_\_\_\_ YRS.

YES  NO  DESCRIBE: \_\_\_\_\_

HAVE YOU HAD ANY MAJOR SURGERIES?

YES  NO  DESCRIBE: \_\_\_\_\_

PLEASE CHECK BELOW ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

BREATHING PROBLEMS

VARICOSE VEINS

LEG CRAMPS/CLAUDICATION

HEART PROBLEMS

NEURO MUSCULAR/NEUROPATHY

TUMORS

BLEEDING PROBLEMS

CANCER

GOUT

EPILEPSY/SEIZURES

VISION PROBLEMS

STROKE

HIGH BLOOD PRESSURE

KIDNEY PROBLEMS

ANEMIA

NERVOUSNESS/ANXIETY/DEPRESSION

RHEUMATISM/ARTHRITIS

ASTHMA

STOMACH ULCERS

TUBERCULOSIS

HEARING DIFFICULTIES

SWELLING OF FEET/ANKLES

LIVER/HEPATITIS

DO YOU HAVE ANY ARTIFICIAL JOINTS?

OTHER

DO YOU HAVE A HEART VALVE IMPLANT OR PACEMAKER?

HIP YES  NO

KNEE YES  NO

EXPLAIN: \_\_\_\_\_

YES  NO

IS THERE ANYTHING OTHER THAN WHAT IS LISTED ABOVE THAT WE SHOULD KNOW ABOUT YOUR HEALTH? \_\_\_\_\_

WOMEN: IS THERE A POSSIBILITY OF YOU BEING PREGNANT? \_\_\_\_\_

## SOCIAL HISTORY

DO YOU SMOKE? IF YES, # OF PACKS PER DAY

YES  NO

DID YOU EVER SMOKE? IF YES, HOW MANY YEARS?

YES  NO

DO YOU DRINK ALCOHOL OR BEER?

YES  NO

MODERATE USE 1-2 PER DAY

LIGHT USE 1-2 PER WK

HEAVY USE MORE THAN 2+ DAILY

EMPLOYMENT:

SITS AT JOB  STANDS AT JOB  STANDS & WALKS AT JOB  RETIRED

WHAT IS YOUR OCCUPATION? \_\_\_\_\_

ARE YOU INVOLVED IN ANY ATHLETIC ACTIVITIES? YES  NO  PLEASE LIST: \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature