

WOODLAKE PODIATRY GROUP

PATIENT INFORMATION FORM

Today's Date ____/____/____ Date of Birth ____/____/____ Age _____ Male _____ Female _____

Name _____
(Please print)

Social Security # _____ E-mail _____

Address _____

City _____ State _____ Zip Code _____

Home Telephone # _____ Work Telephone # _____ Cell Telephone# _____

Primary Physician Name _____ Date Last Seen _____

Who should we thank for the referral? _____

Marital Status Single Married Engaged Separated Divorced Widow Widower Spouse' Name _____

Race/Ethnicity _____ Primary Language Spoken _____

Place of Employment _____ Occupation _____

Height _____ Weight _____ Shoe Size _____

Smoking Status Yes No Previous Smoker Yes No Have you had your flu shot this year? Yes No

MEDICAL HISTORY:

Any known allergies? _____

Are you allergic to any medications? No Yes (please specify below)

- Penicillin Codeine Cortisone Anesthetics / Novocain
- Vicodin Demerol Aspirin Iodine / Betadine Other _____

Current Medication Taken _____

Have you had or ever been treated for the following? (Please circle)

- Diabetes High Blood Pressure Circulation Problems Heart Disease
- Arthritis Rheumatic Fever Drug Reactions Asthma
- Epilepsy Liver or Kidney Disease Blood Clots Stroke
- Other Health Problems _____

Surgical History _____

Family History of Illness _____

What is your foot/ankle problem? _____

How long have you had this problem? _____

Have you seen another podiatrist before today? _____

REFERRED BY:

Doctor _____ Address _____ City _____ ZIP _____

Patient or Friend (please list) _____

Internet (please specify) Google Yahoo Bing Facebook Linked-In

Other (please list) _____

Signature _____ Date _____