PODIATRY CARE SPECIALISTS, P.C.

"Dedicated to getting you back on your feet as soon as possible"

DR. THEODORE G. MUSHLIN **DR. CHAD J. FRIEDMAN**
DR. BRADFORD J. JACOBS **DR. ALEXANDRA K. GRULKE**

KINDLY ASSIST US BY COMPLETING THE FOLLOWING INFORMATION AS CLEARLY AS POSSIBLE.
THANK YOU FOR YOUR COOPERATION.

NAME ______________________________ BIRTHDATE / /

ADDRESS ______________________________

CITY ______________________ STATE ________ ZIP________________

PHONE #' HOME ________________ WORK_____________ CELL______________

EMAIL__________________________ EMERGENCY CONTACT & PHONE______________________

Single Married Partner Divorced Widowed Legally Separated MALE FEMALE

RACE (Optional): White AfrAmer/Black Asian Native Hawaiian or Other Pacific Islander Amer Indian or Alaska Native
ETHNICITY (Optional): Hispanic or Latino Not Hispanic or Latino

INSUANCE INFORMATION: Please present your card(s) to a staff member to copy your insurance and group numbers

PRIMARY MEDICAL INSURANCE COMPANY____________________ ______________

SECONDARY MEDICAL INSURANCE COMPANY______________________________

SUBSCRIBERS NAME________________________RELATIONSHIP TO PATIENT___________

SUBSCRIBERS DATE OF BIRTH / / EMPLOYER____________________

PRIMARY CONCERN -Please **CIRCLE** and if more than one, place a **NUMBER** of importance for each one:
PAINFUL FOOT - LEFT RIGHT BOTH

DIABETES CHECKUP	**NEUROMA**	**BUNION**	**SURGERY CONSULTATION**
FUNGUS NAILS	**PLANTAR FASCIITIS**	**HAMMERTOE**	**ORTHOTICS**
INGROWN TOENAIL	**HEEL PAIN**	**ACHILLES TENDINITIS**	**2ND OPINION**
INJURY TO FOOT/ANKLE	**SPRAIN OR STRAIN**	**DIABETIC SHOES**	**WORK RELATED INJURY**
INFECTION OR ULCERATION	**PLANTAR WARTS**	**CORNS, CALLUSES**	**RASH OR ATHLETE'S FOOT**

OTHER____

PLEASE DESCRIBE **PAIN IF ANY**: SHARP DULL THROBBING BURNING RADIATING NUMBNESS
LOCATION ON FOOT OR ANKLE : TOP BOTTOM INSIDE OUTSIDE TOES WEBS NAILS
HOW LONG HAS THIS BEEN A CONCERN FOR YOU: ______ DAYS WEEKS MONTHS YEARS
PREVIOUS TREATMENT: PLEASE CIRCLE OR CHECK ALL THAT APPLY.

REST	ORAL MEDICATION	PREVIOUS MEDICAL TREATMENT
ICE	PHYSICAL THERAPY	FOOT SURGERY
CHANGE IN SHOE GEAR	ORTHOTIC OR FOOT SUPPORT	CORTISONE INJECTION

OTHERS:____

LAST SEEN BY A PODIATRIST:____________________ **FEMALES**: CURRENTLY PREGNANT Y N

ALLERGIES- PLEASE CIRCLE OR CHECK ALL THAT APPLY. ______**NO KNOWN ALLERGIES**

ASPIRIN	HAY FEVER	SULFA
CORTISONE	IODINE	TAPE
DUST, MOLDS	LOCAL ANESTHETIC	OTHER: ______________
DYES	NUTS	OTHER: ______________
FOOD	PENICILLIN	OTHER: ______________

INITIAL _________ DATE ________ COMPLETE ON OTHER SIDE

MEDICATIONS: PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING: ____ **NOT TAKING ANY MEDICATIONS**

NAME:________________________________ DOSE:_____________ FREQUENCY:_____________
NAME:________________________________ DOSE:_____________ FREQUENCY:_____________
NAME:________________________________ DOSE:_____________ FREQUENCY:_____________
NAME:________________________________ DOSE:_____________ FREQUENCY:_____________
NAME:________________________________ DOSE:_____________ FREQUENCY:_____________
LIST ANY OTHERS____
PHARMACY NAME AND PHONE (IF KNOWN) ____

PAST MEDICAL HISTORY- PLEASE CIRCLE OR CHECK ALL THAT APPLY.

ANEMIA	HEPATITIS	RESPIRATORY PROBLEMS
ARTHRITIS	HIGH BLOOD PRESSURE	RHEUMATIC FEVER
ASTHMA	HIGH CHOLESTEROL	RHEUMATOID ARTHRITIS
BONE DISEASE	JOINT IMPLANT	SCAR ENLARGEMENT
CANCER	KIDNEY DISEASE	SCIATICA
CHEST PAIN	LIVER CONDITIONS	SCOLIOSIS
CIRCULATION PROBLEMS	LUNG PROBLEMS	SEIZURES
DIABETES	LYME DISEASE	STROKE
EYE DISORDERS	MUSCLE DISEASE	STOMACH PROBLEMS
FIBROMYALGIA	NEUROLOGIC DISEASE	THYROID DISEASE
GOUT	OSTEOPOROSIS	TUBERCULOSIS
HEADACHES	PHLEBITIS	ULCERS
HEART ATTACK	PSYCHIATRIC DISORDER	URINARY PROBLEMS
HEART DISEASE		_____ **NO MEDICAL PROBLEMS**

PLEASE LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:
____

PAST SURGICAL HISTORY- PLEASE LIST ANY SURGERIES YOU HAVE HAD: ___**NONE**

SURGERY:____DATE: ________
SURGERY:____DATE: ________
SURGERY:____DATE: ________
LIST OTHERS____

FAMILY HISTORY- PLEASE CHECK OR CIRCLE IF ANY IMMEDIATE FAMILY MEMBERS HAVE OR HAD ANY OF THE FOLLOWING: ____ **NOT KNOWN**

ARTHRITIS	DIABETES
BUNIONS	FOOT DISORDERS
BIRTH DEFECTS	HEART CONDITIONS
BLEEDING PROBLEMS	HYPERTENSION
CANCER	STROKE

SOCIAL HISTORY- DO YOU USE OR HAVE YOU USED ANY OF THE FOLLOWING:

SMOKING HISTORY: NEVER FORMER SMOKER CURRENT EVERYDAY SMOKER OCCASIONAL SMOKER
ALCOHOL USE: YES/ NO SOCIAL MILD MODERATE HEAVY QUIT
HIST. DRUG ABUSE: YES/ NO

PRIMARY CARE/FAMILY PHYSICIAN OR GROUP ____

HEIGHT______ **WEIGHT**_______ **FOR DIABETICS**-LAST DR VISIT______________
BP / **SHOE SIZE**_____ BLOOD SUGAR______ A1c_____

HOW WERE YOU REFERRED TO OUR OFFICE:

Primary Care Physician/Family Physician Internet Web Site Existing Patient
Insurance or Hospital Referral Service Church Bulletin Pediatrician Other Specialist
Newspaper or other Advertisement Phone Book Other_____________________________

I certify that the above information is correct.

PATIENT SIGNATURE_________________________________ DATE_______________