



WEST CHESTER (2 OFFICES) 610-431-0200
 NEWTOWN SQUARE OFFICE 610-356-5911
 SHANNONDELL OFFICE 610-850-0128
 EXTON OFFICE 610-363-1697
 CONCORDVILLE OFFICE 610-459-8191

Dr. Bradford J. Jacobs
 Dr. Alexandra K. Grulke
 Dr. Megan S. Saltzman
 Dr. Vanessa Cardenas
 Dr. Caitlin M. Madden

PLEASE COMPLETE THE FOLLOWING INFORMATION AS CLEARLY AS POSSIBLE. THANK YOU.

NAME: _____ BIRTHDATE: / / _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAYTIME PHONE: _____ EVENING PHONE: _____ CELL: _____

EMAIL: _____ EMERGENCY CONTACT & PHONE: _____

SINGLE MARRIED PARTNER DIVORCED WIDOWED LEGALLY SEPARATED MALE FEMALE

RACE (optional): Caucasian African-American Asian Native Hawaiian or Other Pacific Islander
 American Indian or Alaskan Native

ETHNICITY (optional): Hispanic or Latino Non-Hispanic or Latino

PLEASE PRESENT YOUR INSURANCE CARD(S) TO A STAFF MEMBER TO COPY YOUR POLICY AND GROUP NUMBERS

PRIMARY MEDICAL INSURANCE: _____

SECONDARY MEDICAL INSURANCE: _____

SUBSCRIBERS NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBERS DATE OF BIRTH: / / _____ EMPLOYER: _____

PRIMARY CONCERN: LEFT FOOT RIGHT FOOT BOTH FEET *Please circle all that apply.*

- | | | | |
|-------------------------|-------------------|---------------------|------------------------|
| 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: _____

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 **HOW MANY?**

PREVIOUS TREATMENT: *Please circle all that apply.*

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

OTHER: _____

LAST SEEN BY A PODIATRIST: APPROX. DATE _____ NEVER SEEN FEMALES: CURRENTLY PREGNANT YES NO

HOW WERE YOU REFERRED TO OUR OFFICE?

- Primary Care / Family Physician Internet Website Existing Patient Insurance or Hospital Referral Service
 Church Bulletin Pediatrician Endocrinologist Other Specialist Newspaper or other Advertisement Phone Book
 Other: _____

ALLERGIES: Please circle all that apply.

NO KNOWN ALLERGIES

ASPIRIN	DYES	LOCAL ANESTHETIC	SEASONAL ALLERGIES	OTHER:
CORTISONE	FOOD	NUTS	SULFA	OTHER:
DUST, MOLDS	IODINE	PENICILLIN	TAPE	OTHER:

MEDICATIONS: Please list any medications that you are taking.

NOT TAKING ANY MEDICATIONS

NAME: _____ DOSE: _____ FREQUENCY: _____

NAME: _____ DOSE: _____ FREQUENCY: _____

NAME: _____ DOSE: _____ FREQUENCY: _____

ANY OTHERS: _____

PHARMACY NAME & ADDRESS: _____

PAST MEDICAL HISTORY: Please circle all that apply.

NO MEDICAL PROBLEMS

- | | | | | |
|----------------------|---------------------|--------------------|----------------------|--------------------|
| ANEMIA | EYE DISORDERS | HIGH CHOLESTEROL | OSTEOPOROSIS | SCOLIOSIS |
| ARTHRITIS | FIBROMYALGIA | JOINT IMPLANT | PHLEBITIS | SEASONAL ALLERGIES |
| ASTHMA | GOUT | KIDNEY DISEASE | PSYCHIATRIC DISORDER | SEIZURES STROKE |
| BONE DISEASE | HEADACHES | LIVER CONDITIONS | RESPIRATORY PROBLEMS | STOMACH PROBLEMS |
| CANCER | HEART ATTACK | LUNG PROBLEMS | RHEUMATIC FEVER | THYROID DISEASE |
| CHEST PAIN | HEART DISEASE | LYME DISEASE | RHEUMATOID ARTHRITIS | TUBERCULOSIS |
| CIRCULATION PROBLEMS | HEPATITIS | MUSCLE DISEASE | SCAR ENLARGEMENT | ULCERS |
| DIABETES | HIGH BLOOD PRESSURE | NEUROLOGIC DISEASE | SCIATICA | URINARY PROBLEMS |

LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

PAST SURGICAL HISTORY: Please list any surgeries you have had.

NO PREVIOUS SURGERY

SURGERY: _____ OTHERS: _____

FAMILY HISTORY: Please mark if immediate family members have or had any of the following:

UNKNOWN **UNREMARKABLE**

CONDITION	BLEEDING PROBLEMS	CANCER	DIABETES	HEART DISEASE	HYPERTENSION	STROKE	LIVING	DECEASED
FATHER								
MOTHER								
SIBLING								
CHILDREN								

SOCIAL HISTORY: Do you use or have you used any of the following:

SMOKING: Never Former Smoker Current Everyday Smoker Occasional Smoker

ALCOHOL: No Social Mild Moderate Heavy Quit

PRIMARY CARE / FAMILY PHYSICIAN OR GROUP:

FOR DIABETICS ONLY: Please fill out below.

HEIGHT:	WEIGHT:	LAST DOCTOR'S VISIT:
BLOOD PRESSURE: /	SHOE SIZE:	BLOOD SUGAR: A1c:

I certify that the above information is correct.

PATIENT SIGNATURE: _____ DATE: _____



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