Podiatry Care Specialists, PC

WEST CHESTER (2 OFFICES)	610-431-0200	**Dr. Bradford J. Jacobs**
NEWTOWN SQUARE OFFICE	610-356-5911	**Dr. Chad J. Friedman**
SHANNONDELL OFFICE	610-650-0128	**Dr. Alexandra K. Grulke**
EXTON OFFICE	610-363-1697	**Dr. Aabha M. Suchak**
CONCORDVILLE OFFICE	610-459-8191	**Dr. Megan S. Saltzman**

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:

Complete Other Side >

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: