

# Greensboro Podiatry Associates, P.A.

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

Mailing address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: (Hm / Wk / Cell) \_\_\_\_\_ Alternate Phone: (Hm / Wk / Cell) \_\_\_\_\_

Email address: \_\_\_\_\_ Contact Preference: phone / email / letter

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status: Single / Married / Divorced / Separated / Widowed SS#: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured party's Name: \_\_\_\_\_ Self / Spouse / Parent

Insured party's SS#: \_\_\_\_\_ Insured party's DOB: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

What is your **main** foot problem today?

Do you have any **other** foot problems that need attention?  Yes

No

If Yes, please list those problems.

When did your main problem begin? \_\_\_\_\_

Locate the area of the problem: \_\_\_\_\_

Is the pain:  Burning  Throbbing  Sharp  Dull  Aching  Other \_\_\_\_\_

What causes the problem or makes it worse? \_\_\_\_\_

Was it caused by an injury?  No  Yes

If Yes: please explain: \_\_\_\_\_

What's your: Shoe Size: \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Name and location of your preferred pharmacy: \_\_\_\_\_

Allergies: List all allergies and reactions (includes medication, environmental, and food)  None

Are you allergic to: Adhesive:  No  Yes Latex:  No  Yes

Have you ever been treated for any of the following  None

Condition	No	Yes	If Yes, please provide date and other details:
Diabetes			Duration: _____ Avg. blood sugars: _____
Arthritis (any type)			List: _____
Cancer			Type: _____
Heart disease			
High blood pressure			
High Cholesterol			
Liver problems			
Peripheral Neuropathy			
Reflux disease or GI disorder			
Stroke or Neurological disorder			
Thyroid problems			
Vascular disease to legs			Arterial? _____ Venous? _____
Other			

List ALL MEDICATIONS you currently take (include vitamins or herbal medication):  None

List ALL SURGERIES you have had:  None

Surgery	Date

Have you ever had a **problem with anesthesia**?  No  Yes

If Yes:  Headache after a spinal  Nausea & vomiting  Malignant hyperthermia  
 Other: \_\_\_\_\_

Has any **blood relative** ever had a **problem with anesthesia**?  No  Yes

If Yes: please describe: \_\_\_\_\_

Are you currently a **tobacco** user?  Yes  No  Used to – Quit date: \_\_\_\_\_

If Yes: Type: cigarettes / cigars / pipe / chewing tobacco # of packs per day: \_\_\_\_\_ # of years: \_\_\_\_\_

Do you drink **alcohol**?  Yes  No  Used to – Quit date: \_\_\_\_\_

If Yes: Type: beer / wine / liquor \_\_\_\_\_ drinks per day / week / month / year

Have you used **drugs** such as LSD, marijuana, methamphetamines, cocaine or heroin in the past 2 years?  No  Yes

If yes: please describe: \_\_\_\_\_

**Women Only:** Are you, or do you have reason to think that you might be pregnant?  No  Yes

Is there a **Family History** of any of these disorders?  None

Condition	No	Yes	If Yes: list family members
Allergies			
Arthritis (any)			
Cancer			
Diabetes			
Epilepsy			
Gout			
Heart Attack			
Hypertension			
Kidney disease			
Mental Illness			
Migraines			
Spinal disorder			
Tuberculosis			
Other			

**Do you experience any of the following (check all that apply):**

General:  Fatigue  Weight change  Chills  Fever  Sweats  MRSA  HIV/AIDS

Skin:  Rash  Itching  Sores  Hives  Moles

Head & Neck:  Headache  Pain  Stiffness  Trauma

Eyes:  Glasses  Pain  Infection  Glaucoma

Ears:  Hearing  Infection  Pain  Tinnitus  Vertigo

Nose:  Discharge  Blood  Pain  Allergic Rhinitis

Mouth:  Pain  Sore  Dentures  Swallowing  Dry

Respiratory:  Cough  Sputum  Pain  Asthma  TB  Wheezing  COPD  Pneumonia

Cardiac:  Angina  Murmur  Palpitation  Myocardial Infarct  
 Hypertension  Heart Disease  Arrhythmia

Vascular:  Pain in calf when walking  Phlebitis  Ulcers in legs  Varicose Veins

Abdomen:  Reflux disease  History of stomach ulcers and/or bleeding  Diarrhea  Constipation  
 Hernia  Jaundice  Hepatitis  Cholecystitis

Renal / Urinary:  Kidney stones  Kidney Disease  Dialysis  Blood in urine  Frequency  Stones  
 Incontinence

Hematologic:  Anemia  Bruising  Bleeding or clotting disorders

Endocrine:  Thyroid Disease  Diabetes

Musculoskeletal:  Pain  Stiffness  Weakness  Swelling  Backache  Cramps  Gout  
 Osteoporosis

Nervous:  Syncope  Seizures  Dizziness  CVA  Memory Problems

Emotional:  Anxiety  Insomnia  Depression  Hallucinations

Do you take antibiotics before routine dental cleanings and/or procedures?  No  Yes