Name (Last, First, M.I.): ____________________

Birth date: __________ Gender (circle one): M F Social Security #: __________

The following information is now required by electronic medical record software and in no way will be used in a discriminatory manner.

Email: ____________________
Work #: __________ Cell #: __________
Home #:

Address: ____________________
____
Apt #: ______ City: __________ State: ______ Zip: ______

Emergency Contact: __________ Phone: __________

Primary Insurance Name: ____________________

Secondary Insurance Name: ____________________

Is this a work injury? : ☐ Yes ☐ No

Pharmacy Name: ____________________

Pharmacy Phone: ____________________

Pharmacy Address: ____________________
____
____

Ethnicity:
- ☐ Non-Hispanic
- ☐ Hispanic

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other: __________

Race:
- ☐ African
- ☐ Asian
- ☐ Caucasian
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other: __________

Primary Care Doctor:

____

Date last seen:

____

Referred by:

SURGERIES: ____________________
____
____
____

HOSPITALIZATIONS: ____________________
____
____
____

INJURIES/ TRAUMA: ____________________
____

FAMILY HISTORY: ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer
☐ Other: ____________________

PATIENT SIGNATURE: ____________________ DATE: __________

8200 NW 27th Street ♦ Doral, FL 33122 ♦ 786-662-3893

Name (Last, First, M.I.):______________________________

Reason for visit / Chief Complaint: ______________________________

How long has this been present? ______________ Have you seen a podiatrist before? ☐ Yes ☐

Height: __________ Weight: ______________ Shoe Size: ______________ Are you pregnant?: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Living Situation: ☐ Alone ☐ With Family/Friends ☐ Nursing facility / Rehab

Do you use: ☐ Alcohol ☐ Tobacco ☐ Illicit Drugs Occupation:

Do you currently smoke?: ☐ Yes ☐ No Packs per day?: __________ Years?: _______

If no, Have you ever smoked? ☐ Yes ☐ No Quit Date: ________________

PAST MEDICAL CONDITIONS:

☐ No known medical problems

☐ Diabetes
☐ High Blood Pressure
☐ Poor Circulation
☐ Heart Disease
☐ Kidney Disease
☐ Liver Disease
☐ Gout
☐ Heart Attack
☐ Stroke
☐ Stomach Ulcers
☐ Cancer
☐ Asthma
☐ Thyroid Disease
☐ Blood clots
☐ Anemia
☐ Dialysis
☐ HIV/AIDS
☐ Hepatitis
☐ Other: ______________

MEDICATIONS: Dosage / How Often

☐ I don't take any medications

____
____
____
____
____
____
____
____
____
____
____

ALLERGIES TO MEDICATIONS:

☐ I am not allergic to anything that I am aware of.

☐ Iodine ☐ Penicillin ☐ Aspirin ☐ Anesthesia / Novocaine
☐ Codeine ☐ Sulfa ☐ Cortisone ☐ Adhesive / Tape on the skin
☐ OTHER: ______________________________

Explain in detail what happens when you are exposed to the above:

____
____

Date this first occurred: ______________________________

PATIENT SIGNATURE: ______________________________ DATE:______________