PODIATRY INTAKE SHEET

Patient Name: _____ **DOB**_____

Preferred Pharmacy - Name/Address: _____

Preferred Laboratory – Name/Address:_____

Email Address: _____

CURRENT MEDICAL INFORMATON

What is the reason for your visit today? _____

Height:_____ Weight: _____

Pain Scale from 1 to 10 (10 being the worst?) _____

ALLERGIES

Please list any allergies you have and the adverse reaction.

Allergic to:	**Physical Response:**
1._____	_____
2._____	_____
3._____	_____
4._____	_____

MEDICATIONS

1._____	_____
2._____	_____
3._____	_____
4._____	_____

Patient Name: _____ **DOB:** _____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Y or N	Fever	Y or N	Night Sweats
Y or N	Shortness of breath	Y or N	Chest Pain
Y or N	Muscle Aches	Y or N	Muscle Weakness
Y or N	Joint Pain	Y or N	Swelling of the extremities
Y or N	Skin rashes	Y or N	Growths or lesions
Y or N	Depression	Y or N	Sleep disturbance

SOCIAL HISTORY

What is your smoking status? Currently Every Day, Currently Some days, Formerly Smoked, Never Smoked

How much do you smoke?

¼ pack per day?	¼ pack per week?
½ pack per day?	½ pack per week?
1 pack per day?	1 pack per week?
2 packs per day?	2 packs per day?
3 packs or more per day?	

Have smoked since what age? _____

What is your alcohol intake? Occasional Moderate Heavy

How many years of alcohol use? _____

Work related Injury? _____ **Auto Accident Injury?** _____

Do you take any illicit drugs? _____ **Are you employed?** _____

Patient Name: _____ **DOB:** _____

PAST MEDICAL HISTORY

Have you experienced any of the following symptoms in the PAST?

Y or N	Arthritis
Y or N	Blood Clots
Y or N	Cancer
Y or N	Coronary Artery Disease
Y or N	Depression/Psychiatric Problems
Y or N	Diabetes
Y or N	Fever, chills, headache
Y or N	Hypertension/High Blood Pressure
Y or N	HIV/AIDS
Y or N	Heart Disease/Problems
Y or N	Hereditary Defects
Y or N	Leg or foot ulcers
Y or N	Osteoporosis
Y or N	Rheumatoid Arthritis
Y or N	Skin rash/boils/problems

FAMILY HISTORY OF MEDICAL PROBLEMS

Please list any past family history of specific medical problems/diseases.

Mother: _____ **Died:** _____

Father: _____ **Died:** _____

Sister: _____ **Died:** _____

Brother: _____ **Died:** _____

Additional: _____ **Died:** _____

PAST SURGERY HISTORY

Please list all past surgery history within the last 10 years, beginning with most recent.

	Surgical Procedure	Date of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____