WELCOME TO PISTONE PODIATRIC FOOT CENTER

PATIENT INFORMATION

Patient Name: *(Last)*_____ *(First)*_____ *(M.I)*____

DOB: _____ Sex: M__F__ Marital Status: _____ SS#_____-_____-_____

Street_____ City_____ State____ Zip_____

Home Tel#_____ Mobile#_____ Other#_____

Email_____ Who may we thank for referring you _____

Primary Care Physician _____ Date of Last Visit_____

Street_____ City_____ State____ Zip_____

EMPLOYMENT STATUS

Employment: __Full Time __Part Time __Unemployed/Retired Student: __Full Time __Part Time

Place Of Employment/School _____ Tel# _____

Street_____ City_____ State____ Zip_____

EMERGENCY AND CONTACT INFORMATION

Emergency Contact: Name: _____ Relationship _____

Contact Tel# Home _____ Mobile _____ Other _____

Due to HIPAA Regulations: If we needed to contact you with test results – Information can be given to:

___ Patient Only ___ Patient or Spouse ___ Anyone answering the phone ___Special Requirement (Fill in Below)

Name _____ Relationship_____ Tel#_____ Other# _____

PATIENT HISTORY

Chief complaint: _____ Appointment Date_____

Is there any personal or family history of diabetes? Self ___ Family member____ No _____
Cigarette/Tobacco use: Yes ___ Years Smoked _____ No ___ Quit ____ How many years ago _____
Do you drink: Alcohol? Yes ____ No____ Amount_____ Caffeine? Yes ___ No ___ Amount_____

Athletic activities: (Please list activity and frequency) _____

_____

Medications (List or attach) _____

_____

_____

Allegies and reaction _____

_____

Pharmacy _____ Location _____

AUTORIZATION AND CONSENT

In signing below, I am acknowledging that all information written is true to the best of my knowledge.

I hereby consent and give permission to Dr. Pistone, medical assistant or designated replacement to administer and perform procedures under the doctor's supervision and as the doctor deems necessary.

Signature: _____ Relationship (If minor) _____ Date: _____

WELCOME TO PISTONE PODIATRIC FOOT CENTER

Patient Name: *(Last)*_____ *(First)*_____ *(M.I)*____ DOB_____

Height _____ Weight _____ Shoe Size _____

PATIENT PODIATRIC HISTORY

Please check all that apply to you:

Ankle Pain ___	Athlete's Foot ___	Bunions ___	Calluses ___
Cold Feet ___	Corns ___	Flat Feet ___	Heel Pain ___
Ingrown Toenails ___	Plantar Warts ___	Tired Feet ___	Tingling in Feet ___
Cramps in Feet or Legs ___	Numbness in Feet or Legs ____		Swelling in Feet or Ankles ___

PATIENT MEDICAL HISTORY

Please check all that apply to you:

AIDS/HIV ___	Fainting ___	Respitory Disease ___
Allergy to Anesthetics ___	Gout ___	Rheumatic Fever ___
Anemia ___	Headaches ___	Shortness of Breath ___
Angina ___	Heart Disease ___	Sinus Problems ___
Arthritis ___	Hemophillia ___	Special Diet ___
Artificial value/joints ___	Hepatitis ___	Stroke ___
Asthma ___	High Blood Pressure ___	Swelling ___
Back Problems ___	Jaundice ___	Swollen Neck Glands ___
Cancer ___	Kidney Problems ___	Tuberculosis ___
Chemical Dependency ___	Liver Disease ___	Ulcer ___
Chest Pain ___	Low Blood Pressure ___	Varicose Veins ___
Circulatory Problems ___	Psychiatric Care ___	Venereal Disease ___
Diabetes ___	Neuropathy ___	Weight Loss ___
Ear Problems ___	Phlebitis ___	
Epilepsy ___	Radiation Treatment ___	
Eye Problems ___	Rash ___	

Hospitalization or Surgery:

Reason:_____ Date: _____	Reason: _____ Date: _____
Reason:_____ Date: _____	Reason: _____ Date: _____
Reason: _____ Date: _____	Reason: _____ Date: _____

YOUR FAMILY MEDICAL HISTORY

Condition:	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___
Stroke	___	___	___	___	___	___
Cancer	___	___	___	___	___	___
Glaucoma	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___
Epilepsy/Convulsions	___	___	___	___	___	___
Kidney Disease	___	___	___	___	___	___
Thyroid Disease	___	___	___	___	___	___
Mental Illness	___	___	___	___	___	___
Osteoporosis	___	___	___	___	___	___

PLEASE VISIT US AT WWW.PISTONEFOOTCENTER.COM OR ON FACEBOOK AT PISTONE PODIATRIC FOOT CENTER