Long Island Foot Care, P.C.

Patient Registration Form: *This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.*

Date: _____ **Name:** _____ **Date of Birth:** _____

Age: _____ **Sex**: ☐ M ☐ F **Marital Status:** ☐ Married ☐ Single ☐ Minor ☐ Widow ☐ Divorced

Address:_____ **Apartment:** _____

Town/City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Cell Phone:** _____ **E-mail:** _____

Primary Doctor: _____ **PCP Phone**: _____

Referred by: _____

How did you hear about us? _____

Emergency Contact Information:

Name: _____ **Relationship:** _____ **Phone Number**: _____

Patient's Parent/Guardian Information**: *(if patient is under 18)***

Name: _____ Phone Number: _____

Demographics:

Preferred Language: ☐ English
☐ Spanish
☐ Other: _____

Pharmacy/Prescription Information:

☐ **Walgreens** ☐ **CVS** ☐ **Wal-Mart** ☐ **Target** ☐ **Chubbuck's** ☐ **Xtra Care** ☐ **Bernhard's** ☐ **Freeport Pharm.**

☐ **Other**: _____

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Phone Number: _____

Are you taking any medications/vitamins? □ Yes □ No

If yes, please list them below:

_____ _____ _____

_____ _____ _____

Are you allergic to any food? **□ Yes** **□ No**
Are you allergic to any antibiotics/medicine? **□ Yes** **□ No**
If yes, please list them below:

☐ No Known Drug Allergies ☐ Seasonal ☐ Peanuts

☐ Sulfur ☐ Penicillin ☐ Iodine

☐ Food: _____ ☐ Antibiotics: _____ ☐Other: _____

History of Present Illness:

Have you ever been to a Podiatrist before: ☐ **Yes** ☐ **No**

If yes, please list: Doctor: _____ Last Visit: _____

Please indicate which foot problems you now have:

• Ankle pain	• Cramps/Numbness in feet or legs	• Ingrown toe nails
• Athlete's foot	• Flat feet	• Plantar warts
• Bunions	• Fungus	• Swelling in ankles or Feet
• Corns & Calluses	• Heel pain	• Other: _____

What discomfort do you have with your feet? ☐ **Left** ☐ **Right**

_____

From a scale from 1-10 how would you rate your pain? Please circle one: 1 2 3 4 5 6 7 8 9 10

What makes the pain better or worse? _____

Athletic activities in which you participate (please list and indicate frequency) _____

Medical History: **Height:** _____ **Weight:** _____ **Shoe Size:** _____

	YES	NO		YES	NO		YES	NO
Anemia	☐	☐	**Dementia**	☐	☐	**Migraines**	☐	☐
Arthritis	☐	☐	**Headaches**	☐	☐	**Poor Circulation**	☐	☐
Asthma	☐	☐	**Epilepsy**	☐	☐	**Pneumonia**	☐	☐
Anxiety	☐	☐	**Lung Disease**	☐	☐	**High Blood Pressure**	☐	☐
Heart Attack	☐	☐	**Heart Disease**	☐	☐	**Low Blood Pressure**	☐	☐
Cancer	☐	☐	**Thyroid Disease**	☐	☐	**Back Problems**	☐	☐
Cholesterol	☐	☐	**Gout**	☐	☐	**AIDS/HIV**	☐	☐
Kidney Stones	☐	☐	**Glaucoma**	☐	☐	**Tuberculosis**	☐	☐
Nervous Condition	☐	☐	**Gastritis**	☐	☐	**Ulcers**	☐	☐
Diabetes If yes, how long? _____	☐	☐	**Hepatitis**	☐	☐	**Neurological Problems**	☐	☐
Depression	☐	☐	**Stroke**	☐	☐	**Other:**		

Please list all hospitalizations and surgeries with dates:

_____ _____ _____

_____ _____ _____

Social History:

Do you smoke? ☐ **Yes** ☐ **No** **Do you consume alcohol?** ☐ **Yes** ☐ **No** **Do you use drugs?** ☐ **Yes** ☐ **No**

If yes, how much daily/weekly and for how long? _____

Is there a possibility you could be pregnant? ☐ **Yes** ☐**No**

Family History:

☐	**Foot problems**	☐	**Cancer**	☐	**Diabetes**
☐	**Heart Disease**	☐	**High Blood Pressure**	☐	**Cholesterol**
☐	**Low Blood Pressure**	☐	**Other:**		

I have read the above questions and I have answered them to the best of my knowledge. I authorize Long Island Foot Care, P.C./Dr. Emilio Goez, staff, and associates to examine and treat me. I authorize the release of any medical information necessary to process medical insurance claims. In case my health insurance policy does not pay or cover my care expenses, I understand that I am responsible for payment.

Signature: X **Date:**