# New Patient Intake Form

Patient Name: ______________________________________________________________________

Today's Date: _______/_______/_______ DOB: _______/_______/_______ Age: ___________ Sex: M F

Home Address: ______________________________________ City/State: _______________ Zip: __________

Home Phone: _______________________________________ May we leave a message? Yes No

Cell Phone: ________________________________________ May we leave a message? Yes No

E-Mail: ____________________________________________________________________________

Marital Status: Single Married Partnered Separated Divorced Widowed

Social Security Number:______________________________________________________________

Do you have a legal guardian or power of attorney? Yes No If yes, please provide legal documentation.

Emergency Contact: _____________________________________ Phone: _____________________________

Primary Care Doctor: _____________________________________ Phone: _____________________________

Pharmacy: ______________________________________________ Phone: _____________________________

Is there a family member or other person that you would like for us to share your medical information? Yes No

If yes, name: _______________________________________________________________________

Who is responsible for payment? ___________________________ Relationship? ________________________

Address: ____________________________________________ City/State: _______________ Zip: _________

**Insurance Information**

Primary Insurance: _____________________________ Member ID: ___________________________________

Secondary Insurance: ___________________________ Member ID: ___________________________________

Who may we thank for referring you to our office: ____________________________________________

# New Patient Intake Form

**Please list all medications you are currently taking (including over the counter meds and herbal supplements)**

| Medication | Dosage/Frequency | Medical Condition Prescribed For? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Do you have any allergies to?**

Medications Anesthesia Foods Tape Latex Shellfish Iodine Other No Known Drug Allergies

**Please list all medications you are allergic to:**

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

# New Patient Intake Form

## Your Medical History

**Have you ever had any of the following?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Acid Reflux/GERD | Yes | No | Gout | Yes | No | Parkinson's Disease | Yes | No |
| Alzheimer's/Dementia | Yes | No | Heart Attack | Yes | No | Poor Circulation/PVD | Yes | No |
| Anemia | Yes | No | Heart Disease | Yes | No | Seizures/Epilepsy | Yes | No |
| Arthritis | Yes | No | Hepatitis | Yes | No | Sickle Cell Disease | Yes | No |
| Asthma | Yes | No | High Blood Pressure | Yes | No | Skin Disorder | Yes | No |
| Atrial Fibrillation | Yes | No | High Cholesterol | Yes | No | Sleep Apnea | Yes | No |
| Bipolar Disorder | Yes | No | HIV+/AIDS | Yes | No | Stomach Ulcers | Yes | No |
| Blood Clots/DVT | Yes | No | Kidney Disease | Yes | No | Stroke | Yes | No |
| Cancer<br>Type: | Yes | No | Liver Disease | Yes | No | Thyroid Disease | Yes | No |
| Cerebral Palsy | Yes | No | Lupus | Yes | No | Tuberculosis | Yes | No |
| Crohn's Disease | Yes | No | Migraine/<br>Headache | Yes | No | | Yes | No |
| Depression/Anxiety | Yes | No | Mitral Valve Prolapse | Yes | No | | Yes | No |
| Diabetes T1 T2 | Yes | No | Neuropathy/Nerve Condition | Yes | No | | Yes | No |
| Fibromyalgia | Yes | No | Open Sores | Yes | No | Other: | | |

**Please list all prior surgeries:**

| Type of Surgery | Date | Type of Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# New Patient Intake Form

## Family History

**Do you have a family history of?**

| Condition | Mother | Father |
|---|---|---|
| Diabetes | | |
| Cancer | | |
| Heart Disease | | |
| High Blood Pressure | | |
| Stroke | | |
| Coronary artery disease | | |
| Thyroid Disorder | | |
| Rheumatoid arthritis | | |
| Other | | |

## Social History

Use of alcohol: Never Occasionally No longer use History of alcohol abuse

Use of Tobacco: Never Current Smoker _______packs a day for _________ years Quit ________ ago

Use of recreational drugs: Never Current Use – Type_____________________ for how long? ______________

Employer: _______________________________________ Occupation: ________________________________

How much are you on your feet at work: 10% 25% 50% 75% 100%

Do you exercise? Never Rarely Occasionally Weekly Several times a week Daily

Type of exercise: _____________________________________________________________________________

Barber Podiatry

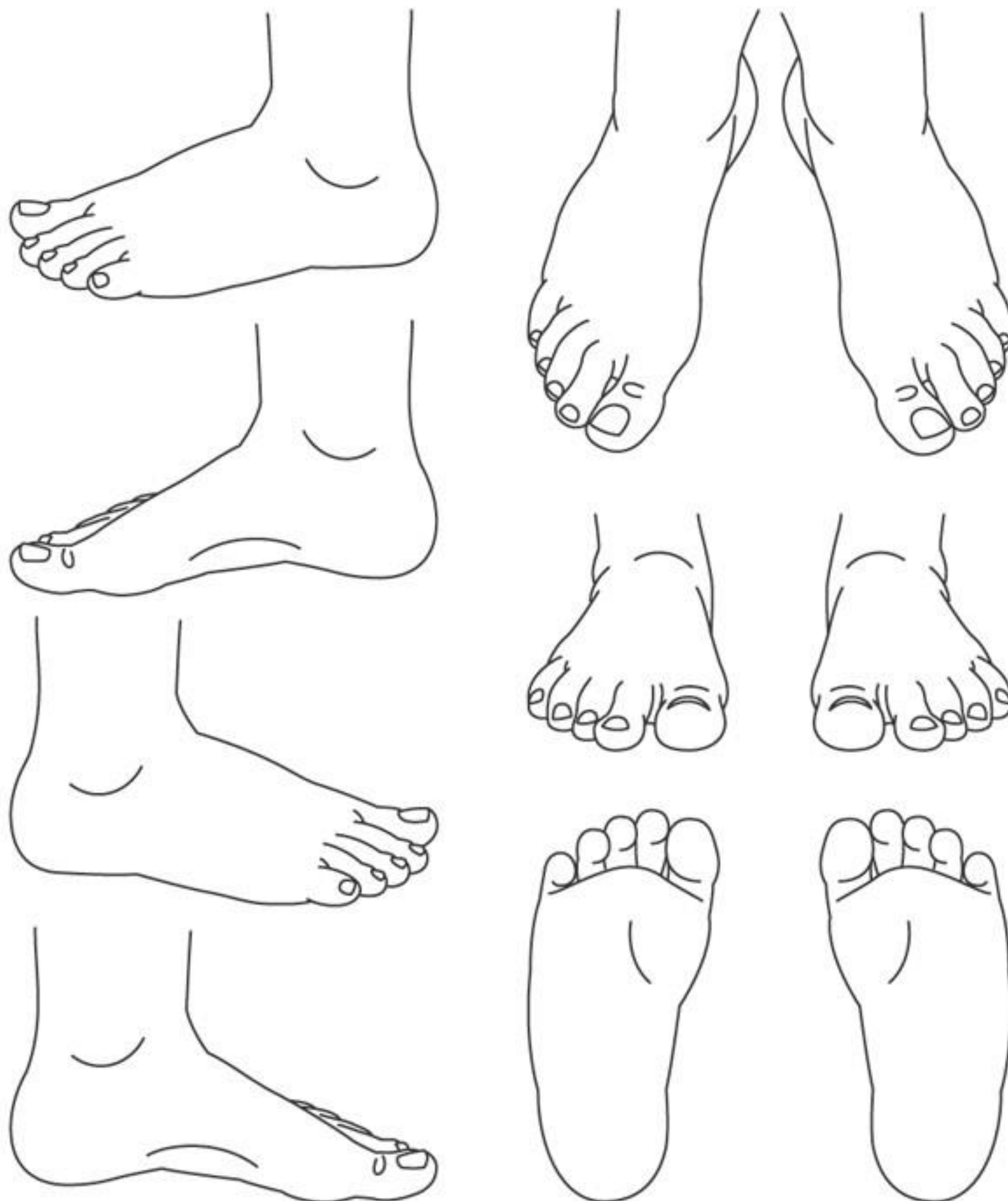
# New Patient Intake Form

Current Problem

What specific problem brings you to our office today? ______________________________________________

______________________________________________________________________________

Where is the pain/problem located? Mark on the pictures below:



# New Patient Intake Form

How long ago did this problem start? ______________________ days / weeks/ months / years

Did you pain or problem begin: All of a sudden Gradually develop over time

How would you describe your pain? No pain Sharp Dull Aching Burning Radiating Itching Stabbing

How would you rate your pain on a scale from 1 to 10? 0 1 2 3 4 5 6 7 8 9 10

Since the time your pain or problem began, has it: Stayed the same Become worse

Improved What makes your pain or problem feel worse?

Walking Standing Daily activities Resting Dress shoes High heels Flat shoes Closed toe shoes

What makes your pain or problem feel better? ___________________________________________________

________________________________________________________________________________________

What treatments have you had for this problem? _________________________________________________

________________________________________________________________________________________

How has this problem affected your lifestyle or ability to work? _______________________________________

________________________________________________________________________________________

Was this problem caused by a work-related injury? No/Yes Describe:___________________________________

Have you previously seen a Podiatrist or Foot/Ankle Specialist for any prior condition? YES/NO
If yes, by whom?__________________________________________________ When:_________________

________________________________________________________________________________________

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_______________________________________ _____________________________________

**Print Name of Patient** **Signature of Patient**

# New Patient Intake Form

**Do I need a Test for PAD?**

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

Name:_____________________________________________ Date:_________________________________

| # | Question | | |
|---|---|---|---|
| 1 | Do you experience any pain in your legs or feet while at rest? | YES | NO |
| 2 | Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hips or thighs during walking/exercise? | YES | NO |
| 3 | If yes to Question 2, does the pain go away when you stop walking/exercising? | YES | NO |
| 4 | Do your feet get pale, discolored, or bluish at any time during the day? | YES | NO |
| 5 | Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks? | YES | NO |
| 6 | Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication? | YES | NO |
| 7 | Do you have high blood pressure or take medication to reduce blood pressure? | YES | NO |
| 8 | Do you have diabetes? | YES | NO |
| 9 | Do you have a history of chronic kidney disease? | YES | NO |
| 10 | Do you currently or have you ever smoked? | YES | NO |
| 11 | Do you have a history of stroke or mini stroke (TIA)? | YES | NO |
| 12 | Do you have a history of heart disease (heart attack, MI)? | YES | NO |
| 13 | Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm), or stent placement? | YES | NO |