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 release 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: _____

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: _____ ☐_____

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?

_____

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 also 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:** _____