PODIATRY ASSOCIATES OF LAKE COUNTY, INC

161 East Washington St
Painesville, OH 44077
Telephone: (440) 352-2201
Fax: (440) 352-0242

1515 Portage St NW, Suite A
North Canton, OH
Telephone: (330) 494-4949
Fax: (330) 494-4945

INFORMATION SHEET FOR PATIENT: **TODAY'S DATE**_____

Your Name: _____ Complaint: _____

Address: _____
(Street) (City) (Zip Code)

Date of birth: _____ Age: _____ Male: _____ Female: _____

Home phone: _____Cell phone: _____ _____ Work phone: _____

Social Security Number: _____ Minor: ___ Single: ___Married: ___Divorced: ___ Widowed: ___

Who referred you to this office: _____ Family physician name: _____

Do you have a current DNR Order (Do Not Resuscitate)? Yes_____ No _____

Have you had an Influenza Immunization (FLU) within the last 6 months? Yes_____ No _____

Have you ever had a Pneumonia Vaccination during your lifetime? Yes _____ No _____

Do you have Diabetes? Type 1 _____ Type 2 _____ No _____ Do you have high blood pressure? Yes _____ No _____

E-mail address: _____

Ethnicity: _____ Primary language: _____

I authorize Podiatry Associates of Lake County, Inc. to leave information regarding me, be it general appointment information or health information, at all phone numbers given above. I hereby authorize Podiatry Associates of Lake County, Inc. to release any information to my medical/surgical insurer.

Patient/Guardian Signature: _____

I authorize my medical/surgical insurance carrier to pay directly to Podiatry Associates of Lake County, Inc. any amount that may be payable for his/her services on my behalf, and that I am responsible for any amount not covered by my insurance carrier. If I have no insurance, I realize that I am responsible for full payment.

Patient/Guardian Signature: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____SECONDARY INSURANCE _____
RESPONSIBLE PARTY_____ RESPONSIBILITY PARTY_____
SUBSCRIBER NAME_____ SUBSCRIBER DATE OF BIRTH_____

EMERGENCY CONTACT NAME AND PHONE NUMBER_____

MEDICAL HISTORY

NAME_____ **DATE**_____

What is your shoe size? Right Foot_____ Left Foot _____

What are your present foot problems? _____

How long have you had these problems? _____

Do you currently have or have you previously had any of the following conditions? Please check the appropriate box.

	YES	NO	FAMILY		YES	NO	FAMILY
Anemia (low blood count)	___	___	_____	Hepatitis: Type	___	___	_____
Arthritis	___	___	_____	High Blood Pressure	___	___	_____
Back Problems	___	___	_____	HIV/AIDS	___	___	_____
Blood Disease	___	___	_____	Kidney Disease	___	___	_____
Cancer	___	___	_____	Liver Disease	___	___	_____
Circulatory Disease	___	___	_____	Low Blood Pressure	___	___	_____
Diabetes Mellitus - Type 1	___	___	_____	Mitral Valve	___	___	_____
Diabetes Mellitus - Type 2	___	___	_____	MRSA Infection	___	___	_____
Depression	___	___	_____	Pacemaker	___	___	_____
DVT (Blood Clots)	___	___	_____	Pneumonia	___	___	_____
Emphysema	___	___	_____	Respiratory Disease	___	___	_____
Epilepsy	___	___	_____	Shortness of Breath	___	___	_____
Heart Murmur	___	___	_____	Stroke	___	___	_____
Heart Disease	___	___	_____	Thyroid Disease	___	___	_____
Ulcerations (foot, leg)	___	___	_____				

SOCIAL HISTORY

Do you currently use tobacco products? Yes____ No ____ Have you used any tobacco products within the last 24 months? Yes ____ No ____
Do you consume alcohol? Yes ____ No ____ If yes, how much per week? _____

SURGICAL HISTORY

Have you ever had knee surgery? Yes___ No___
Have you ever had back surgery? Yes___ No ___
Have you ever had hip surgery? Yes___ No___
Have you ever had foot surgery? Yes___ No___

If yes, what type of foot surgery? _____

Please list your current medications. _____

_____

Please list any allergies to medications, tape or latex._____

_____

NAME OF PHARMACY_____ **LOCATION OF PHARMACY**_____