

PODIATRY ASSOCIATES OF LAKE COUNTY, INC.

Dr. Randi Keefe DPM

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Date: _____

Name: _____

Reason for Visit: _____

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

Date of Birth: _____ Age: _____ Sex: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

How would you like to receive appointment reminders? (circle all that apply): Text Call Email

Social Security Number: _____

Marital Status (circle all that apply): Minor Single Married Divorced Widowed

Race: _____ Primary Language: _____

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino Unknown

Who referred you to this office? _____ Family Physician: _____

Pharmacy: _____ Location: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Authorizations:

- 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 listed above.
- I authorize my medical insurance to pay directly to Podiatry Associates of Lake County, Inc. any amount that may be payable for their services on my behalf and understand that I am responsible for any amount not covered.
- I authorize Podiatry Associates of Lake County, Inc to use SureScripts to communicate with my pharmacy in regards to my medication history.

Patient/Guardian Signature: _____

Medical History Continued

Please list your current medications: _____

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

Did you receive a flu shot for the current flu season? Yes No If yes, when? _____

Have you received a pneumonia vaccine during your lifetime? Yes No If yes, when? _____

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

Have you ever had ankle surgery? Yes No

If yes, what type of foot or ankle surgery did you have? _____

When was your surgery? _____

Who performed your surgery? _____

Social History

Do you currently use tobacco products? Yes No

If yes, which products do you use? _____

Have you used any tobacco products in the last 24 months? Yes No

Do you currently use electronic cigarettes? Yes No

Do you currently use marijuana? Yes No

If yes, is it for medical or recreational purposes? _____

Do you consume alcohol? Yes No

If yes, how much per week? _____