

Advanced Foot Care Center of Rochester New Patient Registration Form

1 PATIENT DATA / EMERGENCY NUMBERS							DATE:	STAFF USE	
FIRST NAME: MI: LAST NAME			OCCUPATION:				ACCT #		
SOC. SEC. NO.:		SEX	AGE	D.O.B.	SHOE SIZE	WEIGHT	HEIGHT		REVIEWED:
									<input type="checkbox"/> NEW <input type="checkbox"/> UPDATE
IN CASE OF EMERGENCY CALL:			FRIEND OR RELATIVE NOT LIVING WITH YOU			PREFERRED PHARMACY			
DAY: () -			DAY: () -			ADDRESS:			
EVENING: () -			EVENING: () -			PHONE: () -			

2 PATIENT MEDICAL HISTORY

Have you had/ or been treated for:

<input type="checkbox"/> Ingrown Nails	<input type="checkbox"/> Arch Pain
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Heel Pain
<input type="checkbox"/> Childhood Foot Problems	<input type="checkbox"/> Flat Feet
<input type="checkbox"/> Broken Foot Bone(s)	<input type="checkbox"/> Corns/Callouses
<input type="checkbox"/> Hammertoes	<input type="checkbox"/> Warts
<input type="checkbox"/> Numbness	<input type="checkbox"/> Athlete's Foot
<input type="checkbox"/> Leg or Foot Ulcers	<input type="checkbox"/> None of These

What percentage of your waking hours do you spend on your feet? (Circle one)

20% 40% 60% 80% 100%

List any sports/ type of dance you are active in:

Do your feet hurt at night? Yes No

Do you have difficulty walking? Yes No

Do you get leg cramps? Yes No

Pain in calves or buttocks when walking? Yes No

Is pain relieved by rest? Yes No

Do you have or have you ever been treated for:

<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Keloid/Thick Scar
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Lyme's Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nerve Disorder	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Non of These

Do you have vascular grafts? (please explain below) Yes No

Do you have joint implants? (please explain below) Yes No

Do you have replacement heart valves? Yes No

Are you under active chemotherapy? Yes No

List relationship to you of family members who have had"

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

of childbirths _____ Are you pregnant? Yes No

Are you slow to heal after cuts? Yes No

Any abnormal bruising, bleeding, scarring? Yes No

Please list any medications

MEDICATION	FOR WHAT PROBLEM?	HOW LONG TAKEN?

Do you smoke now? Yes No Packs/day ___ Years ___

Have you ever smoked? Yes No Packs/day ___ Years ___

If you have quit, when did you do so? _____

Alcoholic beverages? None Rarely Moderately Daily Quit

Recreational drugs? None Rarely Moderately Daily Quit

ALLERGIES: Is there a history of reaction or sickness following an injection, oral or topical administration of:

(check all boxes that apply)	Reaction	
Penicillin.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Antibiotic (list below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Morphine.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Codeine.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Demerol.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Narcotic (list below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Novocain.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Anesthetic (list below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Aspirin.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Empirin / Tylenol (circle one).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Aleve, Motrin or Advil (circle one)...	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Pain Med (list below).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sulfa Drugs.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Adhesive Tape.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Shrimp, Iodine, Merthiolate	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Any other drugs or meds	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Allergic to / Reaction: _____		

Please list all hospitalizations and surgeries and any complications.

<u>SURGERY</u>	<u>DATE</u>	<u>COMPLICATIONS</u>

ILLNESSES/EXPLANATION _____
