North Shore Podiatry, PC
535 Plandome Rd #2
Manhasset, NY 11030
T: 516.365.5544 / F: 516.365.5545

DATE: ___/____/____

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) _____-_____ YES NO

WORK PHONE #: (____) _____-_____ YES NO

CELL PHONE #: (____) _____-_____ YES NO TEXT? YES OR NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

RACE: _____ ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE

EMERGENCY CONTACT: _____RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

DATE OF LAST VISIT WITH PRIMARY CARE DOCTOR: _____

HAVE YOU EVER SEEN A PODIATRIST BEFORE? IF SO, WHEN? DATE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

WHO REFERRED YOU TO US? _____

PATIENT CONSENT FOR PRESCRIPTION HISTORY = PLEASE CHECK ONE:

___PATIENT GIVES CONSENT TO RETRIEVE PRESCRIPTION HISTORY WHEN REQUEST IS TRIGGERED

___PATIENT **DOES NOT** CONSENT TO RETRIEVE PRESCRIPTION HISTORY WHEN REQUEST IS TRIGGERED

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NAME: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?	REASON

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL:

☐ CURRENT: TYPE _____ FREQUENCY: ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET ON A DAILY BASIS? ☐10% ☐25% ☐50% ☐75% ☐100%

EXERCISE: ☐ NEVER ☐RARE ☐ OCCASIONAL ☐WEEKLY ☐SEVERAL TIMES A WEEK ☐DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐CANCER ☐HEART DISEASE
☐HIGH BLOOD PRESSURE ☐STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER: _____

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NAME: _____

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ SHOE SIZE: _____

ALLERGIES: ☐ MEDICATIONS _____
☐ NONE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR 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 ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

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 ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

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 AN INJURY? ☐ NO ☐ YES (DESCRIBE) _____
IF YES, WAS IT A WORK-RELATED INJURY? ☐ NO ☐ YES (DESCRIBE) _____

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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE _____

- 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.

- I HEREBY GIVE CONSENT TO NORTH SHORE PODIATRY P.C, AND ALL HEALTHCARE PROVIDERS FURNISHING CARE ASSOCIATED WITH THIS FACILITY TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____

SIGNATURE

_____

DATE