



*Capital*  
**PODIATRY**  
ASSOCIATES, PC

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[www.capitalfeet.com](http://www.capitalfeet.com)

## Patient Information Form

(Please print)

Date: \_\_/\_\_/\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_  
(Last) (First) (M.I.)

Age: \_\_ Sex:  Male  Female Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

SSN: \_\_-\_\_-\_\_

### How May We Contact You?

	May we Leave a Message?	Text?
Home Phone #: (____) ____-____	<input type="checkbox"/>	<input type="checkbox"/>
Work Phone #: (____) ____-____	<input type="checkbox"/>	<input type="checkbox"/>
Cell Phone #: (____) ____-____	<input type="checkbox"/>	<input type="checkbox"/>
Email: _____	<input type="checkbox"/>	<input type="checkbox"/>
Primary Language: _____		

**Do you have a legal guardian or healthcare power of attorney?**  Yes  No

If yes, Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**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 is responsible for payment?**

Self

Other

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Insurance Information**

**Primary** Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/P.O Box: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Insured Name: \_\_\_\_\_ Date Of Birth: \_\_/\_\_/\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary** Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/P.O Box: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Insured Name: \_\_\_\_\_ Date Of Birth: \_\_/\_\_/\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_

**How did you hear about us?**

Referred by a Physician

Physician name: \_\_\_\_\_

Referred by a friend

Name of friend: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contacted your insurance

Insurance company: \_\_\_\_\_

- Found us online
  - Our website
  - Google Reviews
  - Other Source

Other source: \_\_\_\_\_

- Found us through social media
  - Facebook
  - Twitter
  - LinkedIn
- Other (Please describe)

\_\_\_\_\_

**Social History**

Marital Status:  Single     Married     Seperated     Divorced     Widowed

Use of Alcohol:  Never     No Longer Use- How Long Ago

- Currently Use-  Rare     Occasional     Moderate     Moderate     Weekly     Daily

Use of Tobacco:  Never     No Longer Use- How Long Ago \_\_\_\_\_

- Currently Use-  Rare     Occasional     Moderate     Moderate     Weekly     Daily

Drug Use:  Never     No Longer Use- How Long Ago \_\_\_\_\_

- Currently Use-  Rare     Occasional     Moderate     Moderate     Weekly     Daily

Type of Drug: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**How much are you on your feet at work?**  10%     25%     50%     75%     100%

**Do others depend upon you for their care?**  Children-Age(s)\_\_\_\_\_

Pet(s)-What kind? \_\_\_\_\_  Elderly or Disabled family member

Other \_\_\_\_\_

**Exercise:**  Never     Rare     Occasional     Weekly     Several Times A Week     Daily

Type(s) of exercise: \_\_\_\_\_

**Medical History**

**Allergies:**  Medications: \_\_\_\_\_

Anesthesia: \_\_\_\_\_  Foods: \_\_\_\_\_

Tape     Latex     Shellfish     Iodine     Other \_\_\_\_\_

No Known

**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 \_\_\_\_\_

**Have you ever had any of the following?**

**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:								

**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:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

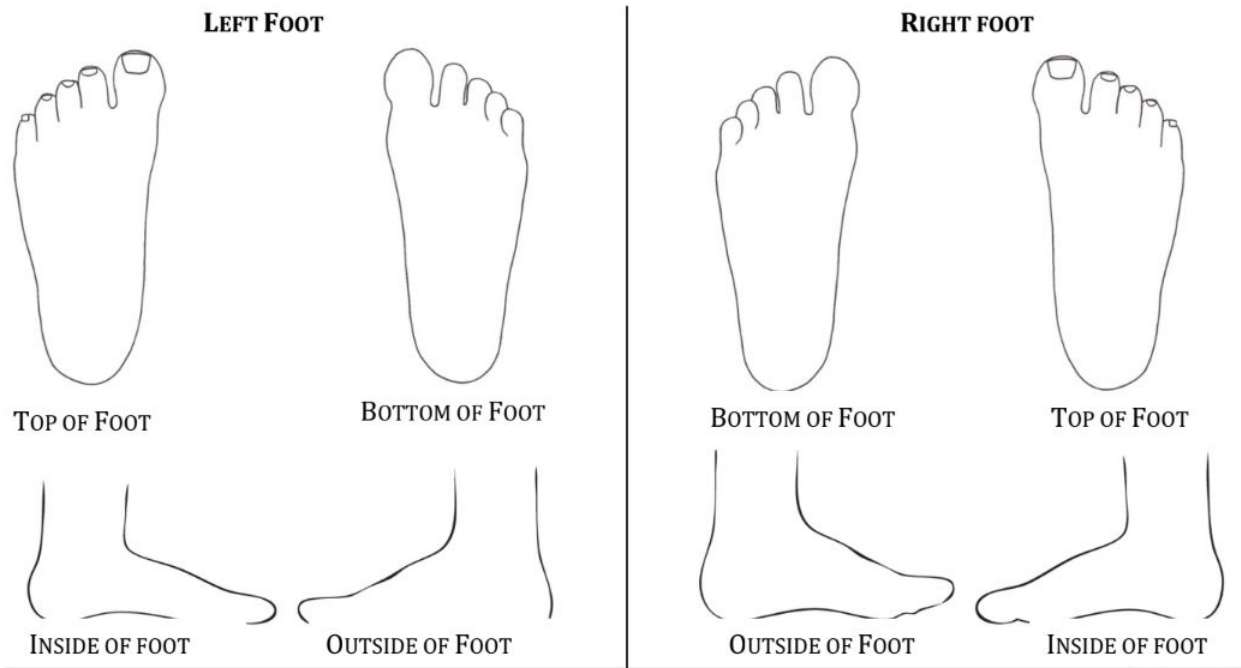
**Current Medications and Prescriptions**

RX _____	Dosage: _____	RX _____	Dosage: _____
RX _____	Dosage: _____	RX _____	Dosage: _____
RX _____	Dosage: _____	RX _____	Dosage: _____

**Current Problem**

What specific problem(s) brings you to our office today? \_\_\_\_\_

Where is the pain/problem located?



**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) 1   2   3   4   5   6   7   8   9   10 (Worst Pain Possible)

**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 treatments have you had for this problem?** \_\_\_\_\_

**Was this problem caused by an injury?**  Yes (Describe) \_\_\_\_\_

No

If yes, was it a work-related injury?  Yes  No

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.

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**Print Name of Patient, Parent or Guardian**

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If other than Patient, Relationship to Patient

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**Signature**

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Signature of Doctor

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Date

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**Date**