WELCOME TO OUR PRACTICE!

WESTERN OHIO PODIATRIC MEDICAL CENTER
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415 West Russ Rd
Greenville, OH 45331
Phone: (937) 548-1244

Please fill in all areas-If not applicable please write N/A

PATIENT INFORMATION: *PLEASE PRINT* **Patient #** _____ **(office use only)**

Name _____
Last Name First Name MI

Street Address_____ **P.O. Box**_____

City_____State_____Zip_____ Home (_____)_____

Cell (_____)_____

Birthdate _____ Sex: ☐ M ☐ F SS# _____

Is this a work related Injury: _____ Date of Injury: _____Claim #:_____

Employer _____ Business Phone (_____)_____

Emergency contact: _____ Relationship_____ Phone_____

Student: ☐ Full-time ☐ Part-time ☐ Not a student **Marital Status**: ☐ Single ☐ Married ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Island ☐ White ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Primary Language**: _____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Please provide the office staff with your insurance cards so we may photocopy them for pertinent insurance information.

(***PLEASE COMPLETE THIS SECTION IF SUBSCRIBER IS OTHER THAN PATIENT***)

Primary Insurance Name_____ Secondary Insurance Name _____

Subscriber's Name_____ Subscriber's Name_____

Subscriber's **Birthdate**_____ Subscriber's **Birthdate** _____

Subscriber's S.S. #_____ Subscriber's S.S. #_____

Relationship to Patient _____ Relationship to Patient _____

Subscriber's Address _____ Subscriber's Address _____

City _____ State _____ Zip _____City _____ State _____ Zip _____

Home Phone _____Home Phone _____

MEDICAL INFORMATION

Describe Your Foot/Ankle Problem: _____

How long have you had this problem? _____

☐ Yes ☐ No Have you had any past problems/surgical procedures performed on your feet and/or ankles?

If Yes, please list _____

Shoe Size _____ Current Weight _____ Height _____

☐ Yes ☐ No Are you under a physician's care? If Yes, for what condition?

_____

Name of **Family Physician** _____ **Pharmacy** _____

☐ Yes ☐ No May we contact your Family Physician about your health?

Check any of the following problems you have/had:

☐ Heart	☐ Skin	☐ Circulation	☐ Stomach Ulcers	☐ Gout
☐ Arthritis	☐ Hormones	☐ Tuberculosis	☐ Healing	☐ Kidneys
☐ Anemia	☐ Rheumatic Fever	☐ Lungs	☐ Frequent Infections	☐ Liver
☐ Bladder	☐ Spleen	☐ Cancer	☐ High Blood Pressure	☐ Intestines
☐ Eye, Ear, Nose or Throat		☐ Asthma/Breathing Difficulty		☐ Bleeding Disorders
☐ Emotional/Psychiatric Disorder		☐ Unexplained Fever/Weight Loss		☐ Neurological

Please **clarify** any above checked problems or unlisted problems or illnesses here: _____

_____

_____

Do you have **Diabetes**? ☐ Yes ☐ No If Yes, do you take insulin? ☐ Yes ☐ No Number of Years? _____

If female, are you **pregnant**? ☐ Yes ☐ No

ALLERGIES / SENSITIVITIES

Are you **allergic/sensitive** to any medications? ☐ Yes ☐ No **If yes**, what medication(s):

_____

_____

Are you allergic or sensitive to tape? ☐ Yes ☐ No Problems with local anesthetics (Novocaine, Lidocaine)? ☐ Yes ☐ No

MEDICATIONS

Please list all **medications** you take on a regular basis. ***(If you have a list of your medications, our office staff will photocopy it.)***

_____

_____

SURGICAL HISTORY

☐ Yes ☐ No Have you had any major surgeries? If Yes, please list _____

_____

☐ Yes ☐ No Do you have any **Artificial Joints**? If Yes, please list _____

☐ Yes ☐ No Do you have a **Heart Valve Implant**?

FAMILY HISTORY

Unknown, adopted: ☐ Yes ☐ No

Mother History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Father History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Brother(s) History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Sister(s) History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Is there any other not previously listed family (blood relative) with a history of: (please specify **maternal or paternal**)

☐ Heart Disease-Who? _____ ☐ Arthritis-Who? _____

☐ Bleeding Disorder-Who? _____ ☐ Neurological Disorder-Who? _____

☐ Stroke-Who? _____ ☐ Bunions-Who? _____

☐ Hammertoes-Who? _____ ☐ Flatfeet-Who? _____

☐ Diabetes-Who? _____

☐ Circulation problems of the legs/feet? -Who? _____

☐ Other and Whom: _____

_____

_____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No What type? _____ How often? _____

Do you use tobacco products? ☐ Yes ☐ No Did you previously? ☐ Yes ☐ No If so, what type: _____

How many per day? _____ How long in use? _____ If applicable, how long ago did you quit? _____

Do you use e-cigarettes? ☐ Yes ☐ No If so, how many per day? _____ How long in use? _____

Employment: ☐ Sit at Job ☐ Stand at Job ☐ Stand and Walk at Job ☐ Retired

Signature _____ **Date** _____