Vanderbilt Orthopaedic Institute

Podiatry

Date: _____

Patient Demographic Information:

Name: _____ Date of Birth: _____ Age: _____
Last First MI

Mailing Address: _____
Street City State Zip

Home Phone: _____ Social Security Number: _____

Cell Phone: _____

Employer Name: _____ Employer Phone: _____

Current Occupation: _____

Marital Status: Single Married Divorced Widowed Separated

Ethnic Group: Asian Black Hispanic Caucasian Other

Sex: _____ Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Mailing Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Who is your Primary Care Physician?:

Name: _____

Mailing Address: _____
Street City State Zip

Office Phone: _____ Office Fax: _____

Who referred you to our office (if other than your primary care physician)?:

Name: _____

Mailing Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Insurance Information: Name of Insurance Co: _____

Visit Information:

What is the reason for your visit today? _____

What was the date of your last medical visit? _____

Did you have x-rays taken at that visit? Yes No

If the patient is a child, is this his/her first visit? Yes No

Is he/she worried about this visit? Yes No

Past Medical History:

Have you ever had an ill effect or are you allergic to penicillin, antibiotics, aspirin, or Novocain?
Yes No

Please list any other drug allergies you may have:

_____

_____

Have you had any complications with previous medical treatment? Yes No
If yes, please list: _____

_____

Do you currently have or have you ever had any of the following conditions?

Aids O Yes O No	Epilepsy O Yes O No	Hypertension O Yes O No
Anemia O Yes O No	Fainting Spells O Yes O No	Kidney Trouble O Yes O No
Arthritis O Yes O No	Frequent Headaches O Yes O No	Rheumatic Fever O Yes O No
Asthma O Yes O No	Glaucoma O Yes O No	Stroke O Yes O No
Blood transfusion O Yes O No	Gout O Yes O No	Tuberculosis O Yes O No
Cancer O Yes O No	Growth O Yes O No	Tumor O Yes O No
Circulation Problems O Yes O No	Heart Murmur O Yes O No	Ulcer O Yes O No
Diabetes O Yes O No Type _____	Heart Attack O Yes O No	Vein/Artery Disease O Yes O No
	Hepatitis O Yes O No	
Drug Addiction O Yes O No	Type _____	Venereal Disease O Yes O No

Are you in generally good health? Yes No

Have you ever been hospitalized or had any surgeries? Yes No
If yes, please list:

_____

_____

_____

Do you currently or have you ever smoked? Yes No
If yes, please list the frequency: _____
Do you currently drink alcoholic beverages? Yes No
If yes, please list the frequency: _____

Did you have any serious childhood diseases? Yes No
If yes, please list: _____

If you are female, is there any possibility that you might be pregnant? Yes No

Please list below any medications you are presently taking or attach a separate sheet of paper with the necessary information:

Medication	Reason
_____	_____
_____	_____
_____	_____

Is there any disease, condition, or problem that is not listed above that we should be aware of?
Yes No
If yes, please explain: _____
_____

Family Medical History:

Have any of your children, brothers, sisters, parents, or grandparents ever had any of the following conditions? (Please specify who has had the conditions):

□Aids	_____	□Glaucoma	_____
□Anemia	_____	□Gout	_____
□Arthritis	_____	□Heart trouble	_____
□Asthma	_____	□Hepatitis (type)	_____
□Blood transfusion	_____	□Hypertension	_____
□Cancer (type)	_____	□Kidney trouble	_____
□Circulation problems	_____	□Stroke	_____
□Diabetes	_____	□Tuberculosis	_____
□Epilepsy	_____	□Ulcer	_____
□Foot problems	_____	□Vein/artery disease	_____

Parents: Mother: □Alive, current age _____
□Deceased, age at time of death _____
Cause of death _____
Father: □Alive, current age _____
□Deceased, age at time of death _____
Cause of death _____

For patients under the age of 18 years of age, please list the person responsible for all charges.

Name: _____ Date of Birth: _____
Last First MI

Mailing Address: _____
Street City State Zip

Home Phone: _____ Social Security Number: _____

Employer Name: _____ Employer Phone: _____

Relationship to the patient: _____

Thank you for completing this form with your information. Please use the remainder of this sheet to share any other information that you feel may need to be considered in your treatment.

I have reviewed and confirmed this information with the patient.

_____***DPM*** _____***Date***