STEINBERG PODIATRY ASSOCIATES, PA

First name _____ MI____ Last Name _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Pharmacy Name _____ Address _____ Phone _____

Email Address (for appointment reminders)_____

Cell phone (for text reminders) _____ Home Phone _____ Work Phone _____

Sex _____ Date of Birth _____ Marital Status _____

Occupation _____ Employer _____

Height _____ Weight _____ Shoe Size _____ Medical Doctor _____

Spouse/Legal Guardian _____

Emergency Contact not living with you _____ Relationship _____ Phone _____

Who referred you to our office _____ Foot complaint _____

Check if you have any of the following:

___Diabetes	___Shingles	___Kidney Disease	___Currently Pregnant
___Rheumatoid Arthritis	___Epilepsy, seizure	___Dialysis	___Thyroid disease
___Osteoarthritis	___Stroke, paralysis	___High Cholesterol	___Anemia
___Gout	___Parkinsons	___Liver Disease	___Blood clots
___Psoriasis	___Cancer	___Hepatitis	___Phlebitis
___Heart Disease	___Lung disease	___Cirrhosis	___Prolonged bleeding
___Congestive Heart Failure	___Asthma	___Stomach Ulcers	___Sickle cell disease
___Heart Attack	___Emphysema	___Diverticulitis	___HIV
___Mitral Valve prolapse	___Tuberculosis	___Hiatal Hernia	___Depression
___High Blood Pressure	___Bronchitis	___Gastric reflux	___Anxiety

Other medical problems not listed above _____

Social: Are you a smoker YES/NO Per day _____ Do you drink alcohol YES / NO drinks per day _____

Activities: Running, walking etc _____

Family history of Diabetes / Heart Disease / Gout / Anesthesia problems _____

Ears: Deafness / Hearing Aid

Previous Surgeries _____

Drug Allergies _____

Medications _____

_____

_____