UNIVERSITY FOOT SPECIALISTS

Kenneth H. Zygmunt, DPM **William M. Noorlag, DPM** **Sakeena I. Haq, DPM**

DATE: ____/____/____

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

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

HOME PHONE #: (___) _____ CELL PHONE #: (___) _____ E-MAIL: _____

PRIMARY LANGUAGE: _____ **ETHNICITY (circle):** 1) Hispanic/Latino 2) Not Hispanic/Latino

RACE (circle): 1) Am. Indian/Alaska Native 2) Asian 3) Black/African American
4) Native Hawaiian/Other Pacific Islander 5) White

SOCIAL SECURITY # _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ PHONE #: (___) ____-_____

ADDRESS: _____

CHIEF COMPLAINT: _____ WHEN DID THIS PROBLEM START? _____

WHO REFERRED YOU TO OUR OFFICE? _____

PRIMARY CARE PHYSICIAN NAME: _____
DATE LAST SEEN

PHONE/ADDRESS: _____

INSURANCE INFORMATION

INSURED NAME: _____ DATE OF BIRTH: ___/___/___ EMPLOYER: _____ PHONE: _____

PRIMARY INSURANCE COMPANY NAME: _____

ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH: ___/___/___ EMPLOYER: _____ PHONE: _____

ID # _____ GROUP # _____

PATIENT HISTORY

ALLERGIES: [ ] NONE KNOWN LATEX ALLERGY: Circle: Yes No SEASONAL ALLERGIES: Circle Yes No

[ ] MEDICATION/ANESTHESIA ALLERGIES _____

[ ] FOOD ALLERGIES _____

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

NAME DOSE FREQUENCY HOW GIVEN

_____

_____

_____

PLEASE DO NOT WRITE BELOW THIS LINE – IF NEEDED, CONTINUE MEDICATIONS LIST ON BACK OF PAGE

UNIVERSITY FOOT SPECIALISTS

Kenneth H. Zygmunt, DPM **William M. Noorlag, DPM** **Sakeena I. Haq, DPM**

PATIENT NAME: _____ DATE: ___/___/___

HAVE YOU OR EITHER OF YOUR PARENTS EVER HAD ANY OF THE FOLLOWING?

PLEASE CIRCLE:

SELF	FATHER	MOTHER					
				S	F	M	HIGH BLOOD PRESSURE
S	F	M	ABNORMAL BLEEDING	S	F	M	HIGH CHOLESTEROL
S	F	M	ANEMIA	S	F	M	HIV/AIDS
S	F	M	ANXIETY/DEPRESSION	S	F	M	LIVER DISEASE
S	F	M	ARTHRITIS	S	F	M	MITRAL VALVE PROLAPSE
S	F	M	ASTHMA	S	F	M	NEUROPATHY
S	F	M	BACK TROUBLE	S	F	M	OSTEOMYELITIS
S	F	M	BLOOD CLOTS/TRANSFUSION	S	F	M	POLIO
S	F	M	BRONCHITIS/EMPHYSEMA/COPD	S	F	M	PNEUMONIA
S	F	M	CANCER	S	F	M	SKIN DISORDER
S	F	M	DIABETES (TYPE I/TYPE II)	S	F	M	SLEEP APNEA
S	F	M	FIBROMYALGIA	S	F	M	STROKE
S	F	M	GERD (ACID REFLUX)	S	F	M	THYROID DISORDER
S	F	M	GOUT	S	F	M	ULCER (FOOT/ANKLE/STOMACH)
S	F	M	HEART DISEASE/FAILURE	S	F	M	OTHER (PLEASE SPECIFY)
S	F	M	HEPATITIS				

PLEASE LIST PRIOR SURGERIES: _____

_____

TOBACCO USER: [ ] YES [ ] NO

FORMER TOBACCO USER: DATE STARTED: _____ DATE STOPPED: _____

WEIGHT: _____ HEIGHT: _____ SHOE SIZE: _____

IF YOU ARE DIABETIC:

Last Fasting Blood Sugar Level _____ Last A1c Test Result _____ Date_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE FILING, AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES PERFORMED. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THE BILL.

SIGNED _____ DATE_____
(PATIENT OR PARENT IF PATIENT IS A MINOR)