

# UNIVERSITY FOOT SPECIALISTS

Kenneth H. Zygmunt, DPM

Guy W. Mattana, 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

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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 CHOLESTEROL
S	F	M	ABNORMAL BLEEDING	S	F	M	HIV/AIDS
S	F	M	ANEMIA	S	F	M	LIVER DISEASE
S	F	M	ANXIETY/DEPRESSION	S	F	M	MITRAL VALVE PROLAPSE
S	F	M	ARTHRITIS	S	F	M	NEUROPATHY
S	F	M	ASTHMA	S	F	M	OSTEOMYELITIS
S	F	M	BACK TROUBLE	S	F	M	PNEUMONIA
S	F	M	BLOOD CLOTS/TRANSFUSION	S	F	M	POLIO
S	F	M	BRONCHITIS/EMPHYSEMA/COPD	S	F	M	SICKLE CELL DISEASE
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	GOUT	S	F	M	THYROID DISORDER
S	F	M	HEART DISEASE/FAILURE	S	F	M	TUBERCULOSIS
S	F	M	HEPATITIS	S	F	M	ULCER (FOOT/ANKLE/STOMACH)
S	F	M	HIGH BLOOD PRESSURE				

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 \_\_\_\_\_  
(PATIENT OR PARENT IF PATIENT IS A MINOR)

DATE \_\_\_\_\_