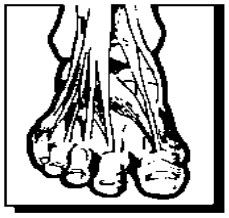

READING

FOOT & ANKLE SPECIALISTS, PC

www.ReadingFootAnkleSpecialists.com (781) 944-8341

PATIENT INFORMATION

Patient's Name_____ Date:_____

First MI Last Home Phone_____

Address_____Cell Phone_____

Street City ZIP Work Phone_____

Email Address_____

____ Married ____Single ____Divorced ____Separated ____Widowed

AGE_____ DATE OF BIRTH____/____/_____ Sex ____Male ____Female

Which PHARMACY do you use_____

Which is the best number to reach you (CHECK ONE) ___HOME ___WORK ___CELL

Primary Care Physician_____Date Last Seen___/___/_____

Employer_____Occupation_____

Employer's Address_____

Street City ZIP

Emergency Contact_____Relationship_____Phone_____

PRIMARY INSURED (CHECK ONE) (if self, do not complete the rest of this section)

_____SELF ____SPOUSE _____PARENT ____CHILD ____Other

NAME_____Home Phone_____

Address_____ Cell Phone_____

DATE OF BIRTH____/____/_____ Sex ____Male ____Female

Employer_____Occupation_____

Employer's Address_____

INSURANCE Primary Insurance Co_____Phone_____

Policy Holder's Name_____POLICY#_____GROUP#_____

Secondary Insurance Company_____Phone_____

If other than self: Policy Holder's Name_____

POLICY#_____GROUP#_____Policy Holder's Date of Birth____/____/_____

Patient's Shoe Size_____ Height_____ Weight_____

REASON FOR TODAY'S VISIT?_____First Date of Onset_____

Did this injury occur at work? Yes No If yes, please describe how:_____

If yes, have you reported this injury to your employer?_____

Referring Doctor:_____Primary Care Physician_____

Have you sought previous treatment for this problem? Yes No

If yes, specify including at-home or professional treatments:_____

PAST MEDICAL HISTORY (please 'x' if you have had any of these in the past)

___Anemia	___Fracture History, please specify:	___Osteoporosis
___Arthritis	_____	___Peripheral Vascular Disease
___Autoimmune Disease	___Fungal Infections	___Psoriasis
___Bleeding Disorders	___Gout	___Rheumatic
___Breathing problems	___Heart Disease	___Sciatica/Back Problems
___Cancer, please specify:	___High Blood Pressure	___Seizure Disorder
_____	___High Cholesterol	___Skin Cancer
___Cellulitis	___ Gastrointestinal Reflux/Ulcers	___Stroke
___Congestive Heart Failure	___Kidney Disease/Dialysis	___Thyroid Problems
___Deep Vein Thrombosis	___Liver Disease	___Varicose Veins
___Neuropathy	___Warts	___Blood Clots: __Legs __Lungs

___Diabetes: ___Diet ___Pill ___Insulin

CURRENT MEDICATIONS ____None ____I take the following medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

I authorize the automated review of medication history Yes_____ No_____

ALLERGIES ____No known allergies ____I have the following allergies

___Penicillin ___Sulfa ___Adhesive/ TAPE ___Cortisone ___Codeine ___Asprin/NSAIDS

___Local anesthetics OTHER:_____

PRIOR SURGERIES

_____ _____

SOCIAL HISTORY

Do You Smoke? ___No I have never smoked ___Yes, I have smoked for ___ years

___Not currently, I quit ___ years ago

Do you drink alcohol? ___Yes, everyday(5/7 days/week) ___No/Rarely ___Yes, occasionally/socially

Substance abuse: ___Yes, I currently have a substance abuse problem Specify:_____

___No, I have never had a substance abuse problem ____Yes, I had a past problem

Do you exercise regularly? ___Yes, I do the following regular exercise:_____

___No, I do not exercise regularly

ARE YOU DIABETIC? ___No If yes, check one: ____Diet Controlled ____Pill Controlled ____Insulin

FAMILY HISTORY (Please specify if parents or siblings had any of the following conditions)

___Diabetes ___Circulatory Problems ___Heart Disease ___Gout ___Blood Clots

___Hypertension/High Blood Pressure ___Other:_____

___Complications with anesthesia

REVIEW OF SYSTEMS (Please mark 'x' if you have any of these symptoms)

Cardiovascular

___Leg pain when walking ___Heart attack
___Chest pain ___Chest pressure/angina
___Leg swelling ___Cold hands/feet
___Leg cramps ___High blood pressure

Eyes, Ears, Mouth, Nose, Throat

___Dizziness ___Glaucoma
___Hearing loss ___Cataracts
___Vision problems

Gastrointestinal

___Abdominal pain ___Indigestion
___Blood in stool ___Vomiting
___Ulcers ___Diarrhea
___Heartburn

Hematologic

___Sickle cell disease ___Clotting disorder
___Anemia ___Bleeding problems
___Use of blood thinners

Musculoskeletal

___Back pain ___Joint swelling
___Muscle weakness ___Sciatica
___Neck pain ___Joint stiffness
___Joint pain ___Joint instability
___Arthritis

General

___Nausea ___Chills
___Fever ___Weight gain/loss

Endocrine

___Diabetes ___Thyroid problems

Genitourinary

___Currently pregnant ___Kidney stones
___Kidney disease ___Excessive urination
___Urinary tract infections

Integumentary

___Athlete's foot ___Nail abnormalities
___Keloids ___Itchiness
___Dry, scaly skin ___Lower leg ulcer
___Rash

Neurological

___Tingling/numbness ___Weakness
___Seizures ___Tremors
___Paralysis

Respiratory

___Difficulty breathing ___Snoring
___Coughing
___Shortness of breath
___Wheezing

PLEASE READAND SIGN: The above information is correct to the best of my knowledge. I understand that throughout my treatment at Caroline Gauthier, DPM I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

_____ _____

Patient/Parent/Guardian **Date**