Welcome to ABQ Podiatry

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Patient Name _____ Birth Date _____
LAST FIRST MIDDLE

Name of (husband, wife, or parent) _____

Address _____ City _____ Zip _____

Home Phone _____ Business/Cell _____ Email _____

Employer _____ Occupation _____

Family Physician _____ Date last seen _____

Who told you about our office? _____ □ Internet □ Phone book □ Newspaper □ Street sign

Former podiatrist _____ Date last seen _____

Name & address of nearest relative _____

INSURANCE INFORMATION

(Please Present Insurance Card / Information to Receptionist)

MEDICAL INFORMATION

What is your foot problem? _____

How long have you had it? _____

List all medications you take _____

Allergies to medications _____

Height (ft/in)_____ Weight (lbs)_____

Do you currently smoke? □ yes □ no Do you drink any alcohol daily? □ yes □ no

List any past surgery _____

Have you ever been treated for any of the following? (check all that apply)

□ Diabetes
□ Sciatica
□ Arthritis / Gout
□ Lung disorder
□ Short leg (R/L)
□ Stomach disorder
□ High blood pressure
□ Heart condition
□ Stroke
□ Circulation problems
□ Kidney disease
□ Liver disease
□ Osteoporosis
□ Depression
□ Thyroid disorder
□ Nerve disorder
□ Alzheimer's disease
□ Cancer _____type

Other _____

Has anyone in your family been diagnosed with diabetes? □ yes □ no

If so, what is his or her relationship to you? _____

CONSENT:

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet. I give permission to release information necessary for my insurance company to process my claim as well as obtain and review my prescriptions.

Signed _____ Date _____