210.829.8770 (v)
210.826.4864 (f)

Alamo Family Foot and Ankle Care

# New Patient Form

## Personal Information

Patient's Name:

Street:

City: State: Zip:

Home Phone: ( ) Cell Phone: ( )

Date of Birth: ☐ Male ☐ Female

Social Security Number:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: Phone: ( )

## Employment Information

Occupation: Employer:

Employer's Address:

City: State: Zip:

Work Phone: ( )

How did you hear about our office?

☐ Google/Internet ☐ Insurance list ☐ Yellow Pages ☐ Tex-Med

☐ Friend/Family Member ☐ Doctor/Clinic:

Please provide name of clinic or doctor

# Medical Information

What brings you to the office today?

Indicate your current pain level:

1 2 3 4 5 6 7 8 9 1

Minimal Moderate Severe

How long have you had this problem?

Name of Family Physician:

Indicate any allergies: No known drug allergies Penicillin Codeine Sulfa Aspirin Anesthetics Iodine

Other allergies:

What medications/dosage are your taking?

Previous surgeries:

Do you use tobacco products? How long? Times per day:

Height: Weight: Shoe size:

## Indicate **if <u>your family has a history</u>** of these medical problems:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Bleeding Disorders
- Other: _____

## Indicate **<u>if you suffer</u>** from these medical problems:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Thyroid Disease | ☐ Heart Disease |
| ☐ Asthma | ☐ Bleeding Disorders | ☐ Mitral Valve Prolapse | ☐ Pacemaker |
| ☐ Heart Burn | ☐ Liver Disease | ☐ UTI | ☐ Blood Clots |
| ☐ Gout | ☐ Osteoarthritis | ☐ Rheumatoid Arthritis | ☐ Seizures |
| ☐ Neuropathy | ☐ Anemia | ☐ Anxiety | ☐ Depression |
| ☐ Osteoporosis | ☐ Kidney Disease | ☐ High Cholesterol | ☐ Cancer |

Other medical problems: _____

## Indicate if you have suffered from any of these symptoms in the last 6 months:

| | | | |
|---|---|---|---|
| Constitution: | ☐ Weight Loss | ☐ Changes in | ☐ Leg Cramps |
| Eyes: | ☐ Blurred vision | ☐ Eye Glasses | ☐ Cataracts |
| Head: | ☐ Hearing problems | ☐ Headache | ☐ Hoarseness |
| Cardiovascular: | ☐ Chest Pain | ☐ Palpitations | ☐ Heart Attack |
| Pulmonary: | ☐ Shortness of Breath | ☐ Cough | ☐ Wheezing |
| Skin: | ☐ Rashes | ☐ Ulcers | ☐ Masses |
| Endocrine: | ☐ Heat Intolerance | ☐ Cold Intolerance | ☐ Hair Loss |

Other: _____

I authorize the release of any medical information necessary to process this claim and request payment of benefits, government or other, to be made to: Alamo Family Foot Care, PA.
I Herby give permission to the physicians of Alamo Family Foot Care, PA to examine, administer treatment and perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.
I Hereby acknowledge the receipt of the privacy practices (Health Information and Portability Act) of Alamo Family Foot Care, PA.

Signature: _____ Date: _____

Email address: _____

Name and address of your preferred pharmacy: _____