UNIVERSITY FOOT SPECIALISTS

Kenneth H. Zygmunt, 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: ______________________________

PHARMACY: ______________________ PHONE# ______________________

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

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)