

NEW PATIENT INFORMATION – (continued)

VITALS:

Height: _____

Weight: _____

Shoe Size: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: ___ **No** ___ **Yes** (please provide details below)

<u>Medication</u>	<u>Describe reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____

Please “” if you have or a family member have had any of the following?

	You	Siblings	Mother	Father	Grandparents
AIDS/HIV	()	()	()	()	()
Anemia	()	()	()	()	()
Back Problems	()	()	()	()	()
Bleeding Problems	()	()	()	()	()
Breathing Problems	()	()	()	()	()
Cancer (type)	()	()	()	()	()
Chronic Fatigue Syn	()	()	()	()	()
AIDS/HIV	()	()	()	()	()
Diabetes	()	()	()	()	()
Epilepsy/Seizures	()	()	()	()	()
Eye Problems	()	()	()	()	()
Fainting	()	()	()	()	()
Foot/leg cramps	()	()	()	()	()
Gout	()	()	()	()	()
Heart Disease	()	()	()	()	()
Hemophilia	()	()	()	()	()
Hepatitis	()	()	()	()	()
High Blood Pressure	()	()	()	()	()
Kidney Problems	()	()	()	()	()
Low Blood Pressure	()	()	()	()	()
Parkinson's Dis.	()	()	()	()	()
Phlebitis	()	()	()	()	()
Rheumatic Fever	()	()	()	()	()
Shortness of Breath	()	()	()	()	()
Sinus Problems	()	()	()	()	()
Stroke	()	()	()	()	()
Swelling	()	()	()	()	()
Tuberculosis	()	()	()	()	()
Varicose veins	()	()	()	()	()
West Nile Virus	()	()	()	()	()

NEW PATIENT INFORMATION – (continued)

MEDICATIONS: Include prescriptions, over-the-counter medications and vitamins:

Surgeries (& year) you have had: _____
(other than foot surgery) _____

SOCIAL HISTORY:

Alcohol: drinks per week?(circle): Occasional <1 1-3 3-6 >10

Employment status (circle): full time part time retired homemaker unemployed

How many hrs/day are you on your feet (circle) ? <1 1-3 3-6 6-10 >10 varies

Marital Status: S M W D

Smoking History : ___ Yes ___ No _____ packs/day _____ How many years?

What is the reason for your visit to the office today? _____

How long has this been a problem? _____

Have you seen any other doctors about this problem? ___ Yes ___ No

Dr's name: _____

Who is your previous podiatrist? _____ Last visit? _____

Have you ever had foot surgery? ___ Yes ___ No

What was done (& how long ago)? _____

Is there anything else you would like the doctor to know? _____

Kenrick J. Dennis, DPM
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

(Please review Notice of Privacy Practices prior to filling in this page)

I acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ **Date of Birth:** _____
(please print)

I request that any and all communications to me (by telephone, mail or otherwise) by *Kenrick J. Dennis, DPM* and/or his staff be handled in the following manner:

• For written communications: Address to: _____
(if different from *Patient Information Sheet*) _____

• For telephone communications: Please list the phones numbers you would like us to use to contact you. Please leave a blank by any # we should **not** use.

_____ Home () _____
_____ Office () _____
_____ Cell Phone () _____
_____ Pager () _____

May we leave a message?
Yes No

Patient Signature

Date