# AUGUSTA PODIATRY ASSOCIATES, PC

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## New Patient Information Form

| Full Name: | | | | Date of Birth: | Age |
|---|---|---|---|---|---|
| Address: | | City: | | State: | Zip: |
| Sex: | SSN: | Home Phone: | | Marital Status: M/S/D/W | |
| Place of Employment: | | Work Phone: | | Alternate Phone: | |
| Spouse's Name: | | Spouse DOB: | | Spouse SSN: | |
| Parent's Name (If patient is a minor) | | Parent's SSN: | | Height: | Weight: |
| Insurance #1 Name: | | | Insurance #1 ID#: | | |
| Insurance #2 Name: | | | Insurance #2 ID#: | | |

### Problem History

In your own words, please describe the problem you are having:

______________________________

______________________________

How much pain are you having (please circle)?

MILD PAIN

NONE (0) 1 2 3 4 5 6 7 8 9 10

Who is your regular doctor? ______________________________

Who referred you to us? ______________________________

### Social History

Do you smoke? YES/NO How much? ______________________________

Do you drink alcohol? YES/NO How much? ______________________________

Occupation: ______________________________

### Medical History

Are you allergic to any medicines (please circle)?

**Penicillin** **Sulfa** **Codeine** **Aspirin** **Adhesive** **Iodine**

Other: ______________________________

Please list any (& all) allergies other than medication:

______________________________

Please list all current medications (& dose) and supplements:

______________________________

______________________________

______________________________

Please list all previous surgeries and hospitalizations:

______________________________

______________________________

______________________________

### Medical Review of Systems

Please check (√) if you or a family member have or have had any of the following:

| Condition | Patient | Family |
|---|---|---|
| Diabetes | | |
| High Blood Pressure/Hypertension | | |
| Heart Attack/Heart Disease | | |
| High Cholesterol | | |
| Poor Circulation | | |
| Stomach Ulcer/Frequent Heartburn | | |
| Cancer | | |
| Frequent Headaches | | |
| Frequent Blurred or Double Vision | | |
| Epilepsy | | |
| Bleeding from the ears or nose | | |
| Thyroid Problems | | |
| Chest Pain/Angina | | |
| Anemia/Low Blood | | |
| Excessive Bleeding | | |
| Difficulty Breathing/Wheezing/Asthma | | |
| Tuberculosis | | |
| Rheumatic Fever | | |
| Pneumonia | | |
| Colon Disease | | |
| Gallbladder Disease | | |
| Kidney Problems | | |
| Liver Disease or Jaundice | | |
| Hepatitis | | |
| Bone or Joint Disease (Arthritis) | | |
| Bursitis/Sciatica | | |
| Phlebitis or Vein Problems | | |
| Leg or Night Cramps | | |
| Tested positive for HIV | | |

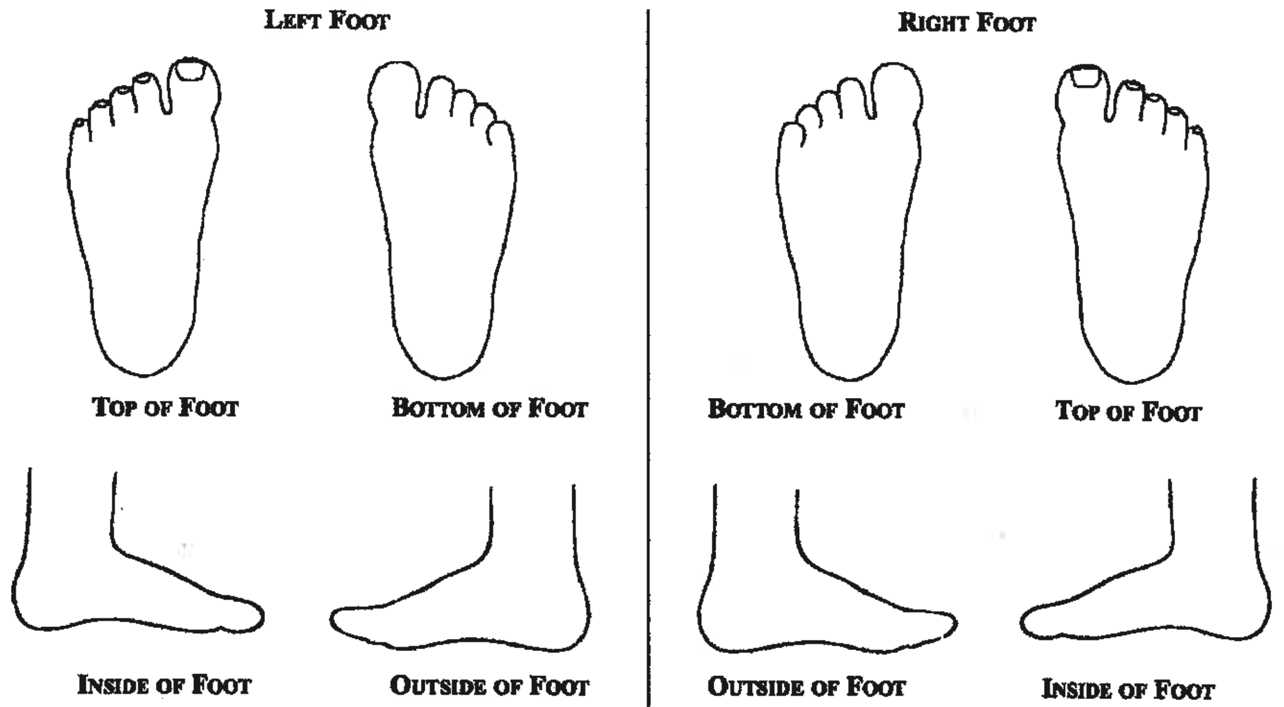
Please list any other medical problems:

Shoe Size: __________ Signature: ______________________________ Date: __________

## Current Problem

What specific problem brings you to our office today? ____________________

Where is the pain/problem located? Please mark on the pictures below.




How long ago did this problem first start? __________ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other __________

Since the time your pain or problem began, has it: ☐ Stayed the same ☐ Become Worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe ☐ Running ☐ Other __________

What makes your pain or problem feel better? ____________________

What treatments have you had for this problem? ____________________

How has this problem affected your lifestyle or ability to work? ____________________

Was this problem caused by an injury? ☐ Yes (describe) ____________________ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

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To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

____________________
Print name of patient, parent or guardian

____________________
Signature of doctor

____________________
If other than parent, relationship to patient

____________________
Date

____________________
Signature

____________________
Date