Welcome to Burlington Podiatry

Patient Information Form - This information is confidential.

Name	Date of Birth	Sex ❑ M ❑ F	Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Residence	City	State	Zip	Phone

Occupation	Work Address	Phone

Spouse's Name, Parent or Guardian if Minor	Spouse's Occupation	Work Address	Phone

Insurance Co. - Primary	Subscriber's Name/DOB	Policy #	Group #

Insurance - Secondary	Subscriber's Name	Policy #	Group #

Type of Pain: ❑ Sharp ❑ Burning ❑ Dull Ache ❑ Sore ❑ Throbbing ❑ Pins & Needles

Describe your foot problem

How long have you had this foot problem?

	YES	NO
Are you in good health?	❑	❑
Have you had any major operations?	❑	❑
Are you pregnant?	❑	❑
Do you smoke?	❑	❑

If you answered NO to any of the first two questions, please explain:

What medications do you take regularly?

Name of Family Physician

Do you or have you had any of the following:

	YES	NO		YES	NO		YES	NO
Diabetes	❑	❑	Rheumatic Fever	❑	❑	Arthritis	❑	❑
if yes, insulin dependent?	❑	❑	Venereal Disease	❑	❑	Ulcers	❑	❑
Heart Disease	❑	❑	Hepatitis	❑	❑	Cancer	❑	❑
High Blood Pressure	❑	❑	HIV Positive	❑	❑	Asthma	❑	❑
Bleeding Disorder	❑	❑	Herpes	❑	❑	Emotional Disorders	❑	❑
Epilepsy	❑	❑	Other					

Is there anything you wish to tell the Doctor privately?

Are you allergic to:	YES	NO
Local Anesthetic	❑	❑
Adhesive Tape	❑	❑
Codeine	❑	❑
Penicillin	❑	❑
Other		

How did you find out about our office?

Shoe Size

Weight

Email Address