MEDICAL INFORMATION—Please fill out as completely as possible

MOUNT KISCO FOOT SPECIALISTS, PLLC

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Name _____ Date of Birth _____

Describe your foot problem _____

How long has it been bothering you? _____

Any past problems with your feet? _____ Any past surgical procedures on your feet? _____

Primary Care Physician _____ Telephone # _____

Address _____

Date of your last exam _____

Date of last flu vaccine?_____Date of last pneumococcal vaccine?_____

Do you have Advanced Directives/Health Care Proxy? **(Circle one)** Yes No

Which pharmacy do you use? _____ Telephone # _____

GENERAL HEALTH INFORMATION

Current Weight _____ Height_____ Shoe Size _____

Do you exercise regularly? _____ Type of Exercise _____

Most of your day is spent (_) sitting (_) standing (_) walking

Are you allergic or sensitive to:

Antibiotics (penicillin, sulfa, etc.) _____

Allergies to other medications? (please list any) _____

Have you had trouble taking aspirin or NSAIDS (Motrin, Advil, Aleve, etc.) _____

Have you had any trouble with local anesthetics (Lidocaine, Novocaine, etc.) _____

Any sensitivity to : Tape _____ Betadine (iodine) _____ Other _____

Please list medical problems you are currently being treated for _____

_____

_____

Please list medications (prescription and over the counter) you are currently taking _____

_____

_____

PLEASE COMPLETE BOTH SIDES

Do you have Diabetes? Yes _____ No _____ If yes, do you take insulin? Yes _____ No _____

Have you ever had any surgeries? (If yes, please list procedures performed)

_____

_____

Do you have any artificial joints, heart valve implants or a heart murmur? _____

Have you been told to take antibiotics before having dental work? _____

Do you smoke or use tobacco products? _____ If yes, # packs/day and for how long

_____

Do you have a history of tobacco use, but you have quit? _____ If yes, how long ago?

_____

Do you have a history of alcohol or other substance abuse? _____

How many alcoholic beverages do you consume in a typical week? _____

Check if you have or had a history of symptoms related to the following:

(_) Eyes, Ears, Nose, Throat (problems with vision, hearing, sinus etc.)
(_) Dermatological disorders (skin cancer, rashes, fungal infections, etc.)
(_) Cardiovascular disorders (high blood pressure, poor circulation, irregular heartbeat etc.)
(_) Endocrine disorders (diabetes, hypothyroidism, etc.)
(_) Gastrointestinal disorders (acid reflux, stomach ulcer, irritable bowel etc.)
(_) Genitourinary disorders (kidney stones bladder problems etc.)
(_) Neurological disorders (dizziness, seizures, tremors, numbness etc.)
(_) Musculoskeletal disorders (joint pain, arthritis, osteoporosis, etc.)
(_) Respiratory disorders (shortness of breath, asthma, emphysema etc.)
(_) Hematological disorders (bleeding/clotting problems, high cholesterol etc.)
(_) Psychiatric disorders (panic attacks, depression, anxiety, etc.)
(_) Infections (Lyme disease, Hepatitis, HIV, sexually transmitted disease)
(_) Constitutional (fever, chills, malaise, unexplained weight loss, etc.)
Please list any other symptoms you are having

_____

FAMILY HISTORY

Is there a family (blood relative) history of (please list relationship)

(_) Diabetes _____ (_) Heart Disease _____
(_) Foot Problems _____ (_) Bleeding Disorders _____
(_) Cancer _____ (_) Arthritis _____
(_) Neurological Problems _____ (_) Other _____

Consent for Treatment

I hereby authorize Jill Berkowitz-Berliner, DPM/Richard Berliner, DPM to perform routine podiatric procedures, including, but not limited to wart removal, ingrown toenails, administration of local anesthetic/cortisone injection in the management of my care. All procedures will be fully explained including risks, alternatives, benefits. This consent will remain in effect until rescinded by myself, or legal representative, in writing.

Signature _____ Date _____