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)

____

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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 any of the the following (circle symptoms):

(_) Eyes, Ears, Nose, Throat (visual changes, hearing loss)
(_) Dermatological disorders (rashes, sores, blisters, growths)
(_) Cardiovascular disorders (chest pain or pressure, arrythmia, palpitations, shortness of breath, swelling in feet or legs, blood clots, varicose veins, cramping in thighs or legs, cold feet)
(_) Endocrine disorders (heat or cold intolerance, excessive thirst)
(_) Gastrointestinal disorders (abdominal pain, heartburn, bloody stool)
(_) Genitourinary disorders (frequent urination, urgency)
(_) Neurological disorders (numbness, tingling, loss of sensation, burning)
(_) Musculoskeletal disorders (joint pain or swelling, restricted motion, muscle or tendon pain or weakness)
(_) Respiratory disorders (shortness of breath, cough, wheezing)
(_) Hematological disorders (bleeding/clotting problems, abnormal bleeding)
(_) Psychiatric disorders (nervousness, anxiety, depression)
(_) Allergy/Immunology (allergic reactions, recurrent infections)
(_) Constitutional (recent weight loss, fever, chills)
Please list any other symptoms you are having

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FAMILY HISTORY

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

(_) Diabetes ______________________________
(_) Foot Problems _________________________
(_) Cancer _______________________________
(_) Neurological Problems __________________
(_) Heart Disease ____________________________
(_) Bleeding Disorders ________________________
(_) Arthritis _________________________________
(_) 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, debridement and biopsy of skin lesions and/or wounds, 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 __________________________