Laser Foot Care of New York
1255 North Ave, 1E
New Rochelle, NY 10804
(914) 365-2500
(914) 365-2501 Fax

PODIATRY NEW PATIENT FORM

Name: ____ Date of Birth: ____________________________

Primary Care Physician: __________________________ Referred by: ____________________________

Cardiologist: ___________________________________ Endocrinologist: __________________________

Nephrologist: __________________________________ Rheumatologist: __________________________

Please describe your problem (include date of injury if applicable)

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Personal Medical History

Check those that apply

	Frequent Headache/Migraines		Anemia/Blood Disorders
	Rheumatic Fever		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy or Seizures
	Diabetes Average Blood Sugar _______		Prolonged Bleeding Time
	Tuberculosis		Stomach/Ulcer Disorder
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems/Tension
	BLOOD CLOTS		Asthma/Hay Fever/ Shortness of Breath
	Tumor/Abnormal Growth/Cancer		Sexually Transmitted Disease
	Ear, Nose, Throat Disorder		Prostate Disorder

Has any family member had any of the following (please indicate relationship)

Cancer: _________________________ Diabetes: _________________________________

Heart Trouble: ___________________ High Blood Pressure: _______________________

Kidney Disease: __________________ Mental or Emotional Disease: _________________

Stroke: _________________________ Tuberculosis: ______________________________

Arthritis: _______________________ Emphysema: ________________________________

BLOOD CLOTS: ________________

Patient Information

Do you smoke currently? ____ Yes ____ No How many packs per day? ______ For how long? _________

Have you smoked previously? ____ Yes ____ No When did you quit? _______

Number of caffeine drinks per day? _______________ Amount of alcohol consumed per week ______________

Please complete the following:

Height: _________ Weight: __________ Shoe size: _______ Occupation: ______________________________

Marital Status: ____Single ____Married ____Divorced ____Widowed

Exercise: Type, duration, and frequency (example: walking 30 minutes 3 x/week)

____

____

____

Allergies

Please check all allergies:

____ Medications: ____

____ foods: ____

____ Tapes ____Novocain ____Anesthetics ____Silver/Nickel/Costume Jewelry ____ Other: _______________

What types of reactions have you experienced?

____

____

Medications

Please list all medications and the dosages:

____

____

____

____

____

Surgical History

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

______________________________ ____

Date Signature