CALO Foot & Ankle Specialists, PLLC

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NEW PATIENT FORM

DATE: ____/____/____
PATIENT NAME: ____________________________ DATE OF BIRTH: ____/____/____ AGE: _____ SEX: M/ F
HOME ADDRESS: __________________________ CITY/STATE: _______________________ ZIP: ____________
SSN: ________________________________ E-MAIL: ________________________________
CELL #: (_____) ____-_______ WORK#: (_____) _____-_______ HOME #: (_____) _____-_______
EMERGENCY CONTACT NAME/NUMBER:
____
PRIMARY CARE DOCTOR NAME:
____
PHONE/ADDRESS:
____
DATE LAST SEEN: __________________________________
PRIMARY LANGUAGE: ___________________________ ETHNICITY: ____________________________________
PHARMACY: _______________________ LOCATION: ________________________PHONE #: (____) ___________

PATIENT HISTORY
ALLERGIES: [ ] NONE KNOWN
[ ] MEDICATION ALLERGIES ____
[ ] ANESTHESIA ALLERGIES __________________________
[ ] FOOD ALLERGIES ______________________________________
OTHER____

PLEASE
LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	FREQUENCY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] ABNORMAL BLEEDING [ ] CANCER [ ] LIVER DISEASE [ ] SKIN DISORDER

[ ] ACID REFLUX [ ] DIABETES [ ] LOW BLOOD PRESSURE [ ] SLEEP APNEA

[ ] ANEMIA [ ] FIBROMYALGIA [ ] MIGRAINE HEADACHES [ ] STOMACH ULCERS

[ ] ARTHRITIS [ ] GOUT [ ] MITRAL VALVE PROLAPSE [ ] STROKE

[ ] ASTHMA [ ] HEART ATTACK [ ] NEUROPATHY [ ] THYROID DISEASE

[ ] BACK TROUBLE [ ] HEART DISEASE/FAILURE [ ] OPEN SORES [ ] TUBERCULOSIS

[ ] BLADDER INFECTIONS [ ] HEPATITIS [ ] PNEUMONIA

[ ] BLOOD CLOTS [ ] HIV/AIDS [ ] POLIO

[ ] BLOOD TRANSFUSION [ ] HIGH BLOOD PRESSURE [ ] RHEUMATIC FEVER

[ ] BRONCHITIS/EMPHYSEMA [ ] KIDNEY DISEASE [ ] SICKLE CELL DISEASE

PLEASE LIST ALL PRIOR SURGERIES:
TYPE OF SURGERY DATE

____

____

____

IF YOU ARE DIBETIC:
Last fasting blood sugar: _______ Last A1c Test: ___________ Shoe size: __________________

SOCIAL HISTORY:
TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

FOR MEDICAL STAFF ONLY:
FOOT EXAM: [ ] TRUE [ ] FALSE
BLOOD PRESSURE: _____________________ PULSE: ______________
WEIGHT: _____________________ HEIGHT: ___________________ TEMPATURE: ________________