ESSEX UNION PODIATRY

New Patient Questionnaire

Name: _____ Date: _____

Phone: (_____)_____ Email: _____

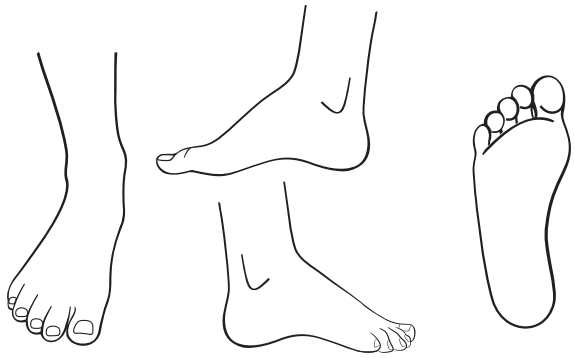
DOB: ____/____/____ Weight: _____ Height: _____ Shoe size: _____

How did you hear about our office?

☐ Website ☐ Social Media ☐ Referral from Physician ☐ Friend/Family Member ☐ Insurance

☐ Online Provider Directory ☐ Brochure/Print Ad Other: _____

Chief Complaint: Circle your area of pain below.



In your own words, tell us what's wrong:

_____

_____

_____

_____

_____

Pain Level: (no pain 0 -10 severe pain) 0 1 2 3 4 5 6 7 8 9 10

Surgical History:

Procedure: **Date of Surgery:**

_____

_____

_____

Medical History: Check any past or current diagnoses.

☐ Anxiety
☐ Arrhythmia (irregular heartbeat)
☐ Asthma
☐ Bleeding problems
☐ Blood clots (DVT/PE)
☐ Cancer
☐ Coronary artery disease
☐ Depression
☐ Diabetes
☐ Heart attack
☐ Heart failure (CHF)
☐ High blood pressure
☐ High cholesterol
☐ Infection
☐ Kidney disease
☐ Open wounds/ulcers
☐ Osteoarthritis
☐ Osteoporosis
☐ Peripheral vascular disease
☐ Pneumonia
☐ Pulmonary embolism
☐ Reflux
☐ Rheumatoid arthritis
☐ Seizures
☐ Stomach ulcers
☐ Stroke
Other: _____

Name: _____ Date: _____

Current Medications:

Name of Medication:	Strength:	Frequency:

Allergies:

Allergy:	Reaction:

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to metals/jewelry? ☐ Yes ☐ No

Are you allergic to iodine? ☐ Yes ☐ No

Social History:

Do you use tobacco? ☐ Yes ☐ No

If yes: _____ packs per day, for _____ months _____ years

Ex-smoker: ☐ Yes ☐ No

If yes: For how many years _____, when did you quit _____?

Do you consume alcohol? ☐ Yes ☐ No

If yes: _____ drinks per day, for _____ months _____ years

Do you use recreational drugs? ☐ Yes ☐ No

List any sports or activities you enjoy: _____

Occupation: _____

Family History:

Family Member:	Health Condition:	Alive/Decease
Mother		
Father		
Maternal Grandparents		
Paternal Grandparents		