MANCHESTER PODIATRY CENTER, P.C.

PLEASE PRINT
PATIENT INFORMATION

NAME_ ______________________________ MOTHER'S MAIDEN NAME______________________
E-MAIL ______________________________
ADDRESS______________________CITY ______________ STATE________ZIP__________
MAILING ADDRESS (IF DIFFERENT) ____
SEX____AGE_______DATE OF BIRTH ____________MARITAL STATUS: M S W D

TELEPHONE AT PATIENT'S RESIDENCE ____________________
CELL____________________
CONTACT PREFERENCES: ___PATIENT ONLY ___PATIENT AND/OR SPOUSE ___ANYONE ANSWERING PHONE
___E-MAIL ______________________

EMERGENCY CONTACT:
NAME ____________________RELATIONSHIP ____________HOME________________
WORK ______________ CELL ________________ E-MAIL __________________

SPOUSE ____

PARTY RESPONSIBLE FOR ACCOUNT:
_____ SELF ___ SPOUSE _____CONSERVATOR/POA
NAME____
ADDRESS______________________ CITY __________ STATE ________ZIP ________
TELEPHONE ________________________
E-MAIL __________________________
CELL____________________________

FAMILY PHYSICIAN ______________________________ TELEPHONE__________________
ADDRESS __________________________CITY __________STATE ________ ZIP______
DATE OF LAST VISIT ____________________

APRN OR NURSE PRACTITIONER ________________TELEPHONE____________________
ADDRESS __________________________ CITY__________ STATE________ ZIP______
DATE OF LAST VISIT____________________

VISITING NURSE ______________________________ TELEPHONE ____________________

OTHER SPECIALIST:1) ____________________ SPECIALTY ____________ TELEPHONE__________
2)____________________ SPECIALTY____________ TELEPHONE__________
3)____________________ SPECIALTY____________ TELEPHONE__________

PHARMACY ____________________TOWN ______________TELEPHONE ______________

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? ______________________________

WHAT IS YOUR CHIEF COMPLAINT/FOOT PROBLEM? ____________________________________

PREVIOUS PODIATRIST____________________ ADDRESS ____________________________

____

SIGNATURE ______________________________ ___PT___ POA___ CONSERVATOR

DATE ____________

Updated 7/14

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/_____

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

NAME

____
____
____
____
____
____
____
____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

____
____
____
____
____
____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

DATE REASON FOR HOSPITALIZATION

__________ ________________________________
__________ ________________________________
__________ ________________________________
__________ ________________________________

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE ______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE __________________

☐ CURRENT USE - TYPE ____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER ____

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____
☐ ANESTHESIA __________________________ ☐ FOODS ______________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________________________
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
SIGNATURE

____
DATE

Manchester Podiatry Center, p.c.

Practice of Podiatric Medicine
and Foot Surgery

KENNETH L. WICHMAN, D.P.M.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________ ____________________
Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

☐ Privacy notice given.

☐ Patient declines.

____
Signature

Due to HIPPA regulations, the use of cel phone's audio or video are not permitted in this office. Thank you for your cooperation.

____
Signature

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