

North Hills Podiatry

Clinton R. Lowery D.P.M.

Michael T. Ryan D.P.M

Jordan Hoachlander D.P.M.

Name: _____ Sex: _____

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home): _____ Other: _____

Employer: _____ Occupation: _____

HT: _____ WT: _____ Shoe Size: _____ Marital Status: _____

Spouse's Name: _____ Spouse's Birthdate: _____

If patient is under 18: Name of Mother: _____ Father: _____

Person who is health insurance subscriber: _____

Local Pharmacy: _____ City: _____ Zip Code: _____

Please check if you have any of the following medical conditions:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Reflux Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Swelling of legs or feet | <input type="checkbox"/> Leg or foot cramps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Do you take aspirin daily | <input type="checkbox"/> Do you smoke |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Have you ever had a stroke | <input type="checkbox"/> Do you exercise regularly |

Do you have a family history of: High Blood Pressure? _____

Heart Disease? _____

Diabetes? _____

Do you have any allergies to medications? _____

Primary Care Doctor: _____ Phone: _____

Reason for your visit today: _____

I hereby give my permission to the doctors of Clinton R Lowery, DPM to administer to perform such minor procedures as may be necessary in the diagnosis and/or treatment of my condition.

Date: _____ Signature: _____

NORTH HILLS PODIATRY

Dr. Clinton R. Lowery

Dr. Michael T. Ryan

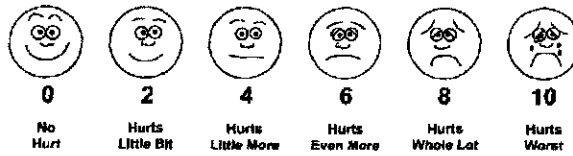
Dr. Jordan Hoachlander

PATIENT QUESTIONNAIRE

Name: _____

Referred by: _____

Pain:



Describe your pain: (sharp, ache, burn, tingling, tightness) _____

Have you had: (swelling, bruising, numbness, tingling) _____

What makes your pain worse? _____

What makes your pain better? _____

How many blocks can you walk? (0-1) (2-4) (4-6) (>7)

Have you had physical therapy? y/n If so when? _____

Do you have difficulty with: (uneven surfaces, stairs, inclines, ladders) _____

List medications you are currently taking:

List surgeries and hospitalizations: _____
