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:

____ Heart Problems	____ Back Problems	____ Reflux Disease
____ Chest Pain	____ Thyroid Disease	____ Liver Disease
____ Circulatory Problems	____ Glaucoma	____ High Blood Pressure
____ High Cholesterol	____ Cataracts	____ Hearing Problems
____ Anemia	____ Swelling of legs or feet	____ Leg or foot cramps
____ Asthma	____ Do you take aspirin daily	____ Do you smoke
____ Stomach Ulcers	____ Tuberculosis	____ Arthritis
____ Diabetes	____ Have you ever had a stroke	____ 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 hearby 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 QUESTIONAIRE

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: _____

_____

_____

_____