ASTORIA FOOT CARE GROUP, P.C.

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WE ARE VERY GLAD TO HAVE YOU WITH US!

The doctors and the staff wish to welcome you to our office. Following are questions to help us become better acquainted. If you need any help, please do not hesitate to ask the podiatric assistant at the desk.

Last Name, First _____ Address and Zip _____

Birthdate _____ Age _____ Home Tel.: _____ Business Tel.: _____

Occupation - Patient _____ Employer _____ Health Insurance _____

Occupation - Spouse _____ Employer _____ Health Insurance _____

Social Security No. _____

Family physician _____ Last visit _____ Former podiatrist _____ Last visit _____

Do you have **Diabetes?** _____ Since when? _____ Family history of Diabetes? _____

List all medications you are taking _____

List any previous operations (including approximate date and where performed) _____

Please Check if you have any of the following

- ☐ Heart Trouble
- ☐ Kidney Trouble
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Stomach Ulcers
- ☐ Broken Bones in Foot/Leg
- ☐ Asthma
- ☐ Cramps or Numbness in Feet or Legs
- ☐ HIV Positive
- ☐ Anemia
- ☐ Blood Disease
- ☐ Circulation Disease
- ☐ Hardening of Arteries
- ☐ Raynaud's Disease
- ☐ Varicose Veins
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Liver Trouble
- ☐ Other

Are you allergic or sensitive to:

- ☐ Penicillin
- ☐ Novocaine
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Adhesive Tape
- ☐ Foods
- ☐ Other Medications _____

What is your foot problem? _____

If applicable: Are you, or are you trying to become pregnant? ☐ Yes ☐ No

Whom may we thank for this referral? _____

Who is financially responsible for your bills? _____

Signature _____ Date _____