CHESTNUT HILL PODIATRY ASSOCIATES—PATIENT INFORMATION

Name	Date of Birth / /
Address	
City/State	Zip Code

Phone(Home)	(Cell)	(Work)
Email		SSN
Primary Care Physician:		
Reason for today's visit:		

OTHER DEMOGRAPHIC INFORMATION

RACE:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Decline to Answer

ETHNICITY:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Answer

SEX: ☐ Male ☐ Female

PRIMARY LANGUAGE: ______________________

INSURANCE INFORMATION

Primary Insurance Company	*Secondary* Insurance Company
ID Number	ID Number
Specialist Copay	Specialist Copay
Subscriber/Policy Holder	Subscriber/Policy Holder
Subscriber's Date of Birth / /	Subscriber's Date of Birth / /
Relationship to Subscriber	Relationship to Subscriber

Person Financially Responsible for Patient: ☐ Self ☐ Other (if other, please complete below)

Name	Date of Birth / /
Address	
City/State	Zip Code
Phone(Home)	(Cell)

Do you take any medications? ☐ No. ☐ Yes. If yes, please list below or provide a list.	
MEDICATION	**DOSE**

Do you have any medical allergies? ☐ No. ☐ Yes. If yes, please list below.	
ALLERGIES	**REACTION**

Have you had any procedures or surgeries? ☐ No. ☐ Yes. If yes, please list below.	
PROCEDURE/SURGERY	**DATE**

Please check if you have, or have had, any of the following medical conditions.	
☐ Alzheimer's Disease	☐ High Blood Pressure
☐ Anemia	☐ High Cholesterol
☐ Anxiety	☐ HIV
☐ Asthma	☐ Kidney Disease
☐ Atrial Fibrillation	☐ Liver Disease
☐ Cancer—type:__________	☐ Lung Disease
☐ Dementia	☐ Migraine Headaches
☐ Depression	☐ Multiple Sclerosis
☐ Diabetes—type:_________	☐ Neurological Disorder
☐ Degenerative Joint Disease	☐ Osteoarthritis
☐ Epilepsy	☐ Peripheral Vascular Disease
☐ Glaucoma	☐ Phlebitis
☐ Gout	☐ Sciatica
☐ Hearing Loss	☐ Stomach Ulcer
☐ Heart Disease	☐ Stroke
☐ Heart Murmur	☐ Thyroid Disorder
☐ Hepatitis—type:_______	

If you have, or have had, any other medical conditions that are not listed above, please list below:

____

____

____

HEIGHT:________________ WEIGHT:_______________

SOCIAL HISTORY

Alcohol Use

☐ Current	☐ Beer
☐ Past	☐ Wine
☐ Never	☐ Liquor (hard)
☐ Other:_________	☐ Liquor (malt)

Tobacco Use

☐ Current (every day)	☐ Cigarettes
☐ Current (some day)	☐ Cigars
☐ Former	☐ Electronic cigarettes
☐ Never	☐ Oral
☐ Other:___________	☐ Pipe

Substance Use/Recreational Drug Use

☐ Current	Substance(s) used:
☐ Past	________________
☐ Never	________________
☐ Other:_________	________________

If diabetic, please list your most recent: Hemoglobin A1c:__________Blood Glucose Level:__________

FAMILY HISTORY	☐ Negative	☐ Unknown	☐ Unable to obtain	☐ Patient adopted				
Please check all that apply.	Mother	Father	Sister	Brother	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)
Cancer								
Diabetes								
Heart Disease								
High Cholesterol								
High Blood Pressure								

PREFERRED PHARMACY:

PHARMACY LOCATION: **PHARMACY PHONE:**