PEDIATRIC Patient Registration Forms Today's Date: _____

Last Name: _____ Home Phone: _____

First Name: _____ Guardian Cell Phone: _____

Address:_____ Date of Birth: _____/_____/_____ Age _____

City: _____ State_____ Zip_____ SSN: _____

County:_____

Gender: ❑Female ❑Male ❑Deferred

Race: ❑African Amer/Black ❑Caucasian/White ❑Deferred ❑Amer Indian/Alaska Native ❑Hispanic/Latino ❑Native Hawaiian/Pac Islander ❑Other _____

Ethnicity: ❑Hispanic, Latino, or Spanish Origin ❑Not Hispanic, Latino, or Spanish Origin

Guardian Employer: _____ City: _____Phone Number: _____

Guardian Email Address: _____

Emergency Contact : _____ Phone: _____ Relationship: _____

PATIENT IS A MINOR OR STUDENT (PLEASE COMPLETE THIS SECTION)

Father's Name: _____ Mother's Name: _____
Address: _____ Address: _____
Phone: _____ home, work, or cell Phone:_____home, work, or cell
Date of Birth: _____/_____ / _____ Date of Birth: _____ / _____ / _____
Social Security Number: _____ - _____ - _____ Social Security Number:_____-_____ - _____
Employer: _____ **Employer:** _____
Address: _____ Address: _____
Phone Number: _____ Phone Number:_____

INSURANCE INFORMATION (Please give receptionist a copy of your card and Complete)

Primary Insurance: _____ Secondary Insurance:_____
Cardholder: _____ Cardholder:_____
ID No._____ Group No. _____ ID No._____ Group No._____
Relationship to Patient: _____ Relationship to Patient:_____

Patient Name: _____

MEDICAL RELEASE INFORMATION

Who may we release medical information to?

1. _____ Phone:_____ Relationship: _____

2. _____ Phone:_____ Relationship: _____

May we leave medical information on the answering machine or voice mail of the phone number(s) you have listed**? Yes No**

REFERRING SECTION (Circle one)

Family Member _____
Doctor _____
Attorney _____

Other _____

PRIMARY CARE PHYSICIAN

Name: _____

City: _____

Phone: _____

PATIENT'S PAST MEDICAL HISTORY *Please check all that apply*

❑ **NO PAST MEDICAL HISTORY**

- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anxiety/Panic Attacks
- ❑ Anesthesia Complications
- ❑ Malignant Hyperthermia
- ❑ Arrhythmia
- ❑ Arthritis/Osteoarthritis
- ❑ Asthma/Lung Disease
- ❑ Bleeding Tendency
- ❑ Blood Clots/DVT
- ❑ Blood Thinners
- ❑ Bone/Joint Infection
- ❑ Bruise Easily
- ❑ Bunions
- ❑ Cancer
  - ❑ Chemo ❑ Radiation
- ❑ Cardiac Problems
- ❑ Carpal Tunnel, Neuropathy
- ❑ Chest Pain, Angina
- ❑ Circulatory Problems
- ❑ Cirrhosis, Jaundice
- ❑ Claustrophobia
- ❑ Deafness or hearing trouble
- ❑ Depression
- ❑ Diabetes ❑ 1 ❑ 2
- ❑ Diverticulitis
- ❑ Emphysema or COPD
- ❑ Fainting/loss of consciousness
- ❑ Fatigue/Weakness
- ❑ Gall Stones
- ❑ Gastritis
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches
- ❑ Heart Attack/MI
- ❑ Heart Condition (congenital)
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ Hiatal Hernia
- ❑ HIV
- ❑ Hypertension (High BP)
- ❑ Irritable Bowel Syndrome
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Kidney Disease
- ❑ Kidney Failure
  - ❑ *Dialysis* ❑ *No Dialysis*
- ❑ Liver Disease
- ❑ Lumbar Disk Disease
- ❑ Lyme Disease
- ❑ Morning Stiffness
- ❑ Multiple Sclerosis
- ❑ Muscle Spasms
- ❑ Muscle Tenderness
- ❑ Muscle Weakness
- ❑ Myasthenia Gravis
- ❑ Numb/Tingling hands/feet
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Palpitations
- ❑ Parkinson's Disease
- ❑ Phlebitis
- ❑ Pneumonia
- ❑ Poly/Fibromyalgia
- ❑ Renal Failure
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Shortness of Breath
- ❑ Skin Problems/Disorders
- ❑ Sleep Apnea
- ❑ Spinal Stenosis
- ❑ Stroke/TIA
- ❑ TB (Tuberculosis)
- ❑ Thyroid High Low
- ❑ TMJ (Jaw locks or pops)
- ❑ Ulcers/Reflux/GERD
- ❑ Vascular/Circulatory
- ❑ Varicose Veins
- ❑ Vertigo
- ❑ Other _____

I have reviewed this Information, and by my signature, attest that the answers are true and accurate to the best of my ability:

_____ _____

Parent/Guardian Signature **Date**

Podiatric and Medical History **Name** _____

Weight_____ Height_____ Shoe Size _____ Shoe Style (Boot, Heel, Athletic, Casual, Dress, Sandals, flip-flops, backless)

Chief Complaint: (What brings you into the office today? Please provide detailed information)

_____

Location: (Where is your pain?) _____

Please indicate the **severity** of the pain or discomfort. (Circle) None Mild Moderate Strong Severe

When did this initially **start**? _____ Days Weeks Months Years **AGO**

How would you **describe** the discomfort? (Circle those that apply)
Sharp Shooting Throbbing Tingling Numb Burning Itching Aching Tender Dull

Have you had any treatment done for this condition? YES NO

If yes, what kind?_____

What **aggravates** the condition? (Circle all that apply) Shoes Walking No Walking Activities

Other _____

Have you ever been treated for any of the following: (please **circle** those that apply)

Corns/Calluses Warts Rash Leg or Foot Ulcers Fungus Nails Athlete's Foot Broken foot bones Neuroma Ingrown Nails
Hammertoes Broken Ankle Foot numbness Cramps in legs/feet Bunions Ankle sprain Lower Back Pai Arch Pain
Gait (walking) problems Knee Pain Childhood Problems In-toeing Toe Walking Flat Feet High Arches
Other: _____

Did you previously or do you now wear?:

Shoe Insoles? _____ If yes, are you still using them? _____ Did they help? _____

Orthotics? _____ If yes, are you still using them? _____ Did they help? _____

Percent of waking hours spent on your feet? 10% 20% 40% 60% 80% 100%

List the sports or activities you are involved in: (Walking, Running, Weights, Cycling, Pilates, Aerobics, Curves, Treadmill)

_____

Family History:

NO PAST MEDICAL HISTORY

Disorder	**Who**			
❑ Bleeding Disorder	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Diabetes 1 or 2	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Heart Disease	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Stroke	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Anesthetic Complic	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
❑ Cancer	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
Type: _____	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
Type: _____	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent
Type: _____	❑ Mother	❑ Father	❑ Sibling	❑ Grandparent

Name _____

Surgical Procedures (You Have Had Performed and approx Date performed):

_____

_____

_____

Hospitalizations (Other than for Surgeries): _____

Medications: (please provide a list to the receptionist if needed)

NAME	Reason for taking	Dose

Pharmacy: _____Location: _____ Phone: _____

Allergies:	YES	NO		YES	NO
Penicillin	_____	_____	Latex	_____	_____
Morphine	_____	_____	Codeine	_____	_____
Novocaine	_____	_____	Other Anesthetics	_____	_____
Aspirin	_____	_____	Advil, Aleve, Motrin	_____	_____
Sulfa Drugs	_____	_____	Adhesive Tape	_____	_____
Shrimp, Iodine, Merthiolate	_____	_____			

Others: _____

_____

CONSENT TO TREATMENT

I certify that the above information is true and correct to the best of my Knowledge. I give my permission to Dr. MacNab to administer and perform such procedures as may be necessary in the diagnosis and/or treatment of my feet.

Patient Signature_____ Date _____

Guardian Signature _____ Date _____