Prima CARE P.C.
Podiatric Medicine & Surgery

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Name: _____ Date of Birth: _____

Address: _____

_____ Height: _____ Weight: _____

_____ Email: _____

Home Phone: _____ Mobile Phone: _____

Describe the problem with your foot/feet?

_____

How long have you experienced this problem? _____

All Medications you take daily or as needed:

_____

_____

Medical History/Problems:

_____

_____

_____

Allergies:

_____

_____

List Surgeries:

_____

_____

Hospitalizations (reason and date):

_____

_____

Social History:

Marital Status: Single Married Separated Divorced Widow(er)

Smoking: Current smoker Former smoker Nonsmoker

Alcohol: None Socially Daily

Drug Use: None Yes (type used) _____

Exercise Routine: _____

Occupation: _____

Turn Page Over

ROS: **Circle any that currently apply**

Fever	Chills	Change in appetite	Change in vision	Post nasal drip
Heat intolerance	Cold Intolerance	Frequent thirst	Frequent urination	Wheezing
Cough	Shortness of breath	Palpitations	Chest Pain	Nausea
Vomiting	Diarrhea	Constipation	Blood in urine	Urinary frequency
Painful Urination	Joint pain	Joint swelling	Muscle pain	Dry skin
Itching	Rash	Ulcers	Dizziness	Headaches
Loss of strength	Tingling/numbness	Depressed mood	Anxiety	Hallucinations

Family History

	Grandparents	**Father**	**Mother**	**Brother/Sister**
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐

_____ _____

Signature (if minor parent or guardian please sign) **Date**