Plymouth Podiatry
America's Hometown Podiatrist

Name: _____ **DOB**:_____

Address: _____

Phone number: _____

Reason for Visit:

Ball of foot pain	Nail pain/discoloration	Athletes foot	Ingrown Nail	Broken Bone
Pain top of foot	Swelling ankle/foot	Ankle Pain	Bunions	Calluses/Corns
Plantar Warts	Flat Feet	Heel Pain	Wounds	Ulcers
Not listed:				

Primary Care Provider: _____ **Date of last visit:** _____

Pharmacy:_____ _____
Name **Address**

Occupation:_____

Medications:(If a list is available please have the receptionist make a copy)

_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

_____ _____
_____ _____
_____ _____
_____ _____

Surgical History:

_____ _____
_____ _____

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Family History: Please circle any that may relate:

Diabetes	Circulatory Issues	Bunions	Hammer Toes
Cancer	Blood Disorder		

Medical History: Please circle any of the following that you have had:

Anemia	Hemophilia	Rheumatic Fever	Circulatory issues	Rash
Diabetes	Shortness of Breath	Chest Pain	Back Problems	Epilepsy
Fainting	Neuropathy	Foot/leg cramps	Chemical Dependency	Stroke
Angina	Hepatitis/jaundice	Kidney problems	Liver disease	Cancer
Arthritis	Radiation	Psychiatric care	Low Blood Pressure	Phlebitis
AIDS/HIV	Tired feet	Heart Disease	Swollen Neck Glands	Ulcers
Artificial Valves	Headaches	High blood pressure	Respiratory Disease	Asthma
Artificial Joints	Radiation	Varicose Veins	Bleeding Disorders	

Social History:
Cigarette/Tobacco Use _____ Years Smoked _____

Emergency Contact:
Name:_____ Phone Number:_____

May we share your medical information with this person? YES NO

Who can we thank for referring you ?_____

Signature: _____ Date:_____