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:** _____

Address: _____

Pharmacy Name: _____ **Address**_____

Occupation: _____

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

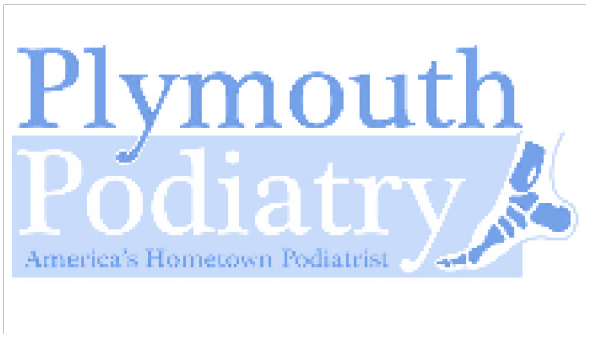
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

_____ _____
_____ _____
_____ _____
_____ _____

Surgical History (Please list Right or Left for anything to do with foot/ankle):

_____ _____
_____ _____



Family History: Please circle any that may relate:

Diabetes	Circulatory Issues	Bunions	Hammer Toes
Cancer (Type):	Blood Disorder		

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

Anemia	Hemophilia	Rheumatic Fever	Circulatory issues	Auto Immune
Diabetes (Type?):	Shortness of Breath	Jaundice	Back Problems	Epilepsy
Syncope	Neuropathy	Foot/leg cramps	Hyper/Hypo Thyroid	Stroke
Angina	Cancer (What Kind):	Kidney problems	Liver disease	Hepatitis
Arthritis	Radiation	Psychiatric care	Low Blood Pressure	Phlebitis
AIDS/HIV	High Cholesterol	Heart Disease	Swollen Neck Glands	Ulcers
Artificial Valves	Headaches	High blood pressure	Respiratory Disease	Asthma
Artificial Joints	Multiple sclerosis	Varicose Veins	Bleeding Disorders	

Social History (Former or Current?):

Cigarette/Tobacco Use _____ Years Smoked _____

Alcohol Use_____ Recreational Drug Use:_____

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:_____