CAPUANO KING PODIATRY

NAME: _____ **DOB:** _____ **SEX:** __M __F

ADDRESS: _____ **CITY:** _____ **STATE:** ___ **ZIP:** _____

HOME#: _____ **CELL#:** _____ **WORK/OTHER:** _____

ETHNICITY: __ ASIAN __ AMERICAN INDIAN OR ALASKA NATIVE __BLACK OR AFRICAN AMERICAN __WHITE __DECLINED TO SPECIFY

__ HISPANIC OR LATINO __NOT HISPANIC OR LATINO __NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

PREFERRED LANGUAGE _____

SPOUSE/PARTNER: _____ **MARITAL STATUS:** __SINGLE __MARRIED __DIVORCED __WIDOWED

EMERGENCY NAME: _____ **EMAIL:** _____

EMPLOYER: _____ **ADDRESS:** _____ **CITY:** _____ **STATE:** ____

PRIMARY CARE PHYSICIAN _____ **PHONE#** _____ **DATE LAST SEEN** _____

PHARMACY NAME _____ **PHONE#** _____ **CITY** _____

SMOKING STATUS: __CURRENT EVERDAY SMOKER ___FORMER SMOKER __ NEVER __DECLINE TO ANSWER

VITAL SIGNS: BLOOD PRESSURE _____/_____ HEIGHT _____ WEIGHT _____

MEDICATIONS:

NAME: _____

NAME: _____

NAME: _____

NAME: _____

NAME: _____

NAME: _____

NAME: _____

ALLERGIES:

NAME: _____

NAME: _____

NAME: _____

NAME: _____

NAME: _____

NAME: _____

NAME: _____

PRIMARY INSURANCE COMPANY: _____ **ARE YOU THE INSURED:** __YES __NO

POLICY # _____ **GROUP#** _____ **EMPLOYER** _____

SUBSCRIBER NAME: _____ **RELATIONSHIP TO THE INSURED:** __SPOUSE __CHILD __OTHER

SECONDARY INSURANCE COMPANY: _____ **POLICY#** _____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE? __PHYSICIAN __INTERNET __FAMILY MEMBER __FRIEND __OTHER

WHAT IS THE REASON FOR YOUR VISIT? _____

HOW LONG HAS THIS BOTHERED YOU? _____ **RESULT OF ACCIDENT OR WORK INJURY?** __YES __NO
WHAT TREATMENTS HAVE YOU TRIED AND WERE THEY EFFETIVE? _____
ON A SCALE OF 1-10 1 BEING NO PAIN AND 10 BEING THE WORST) WHAT IS YOUR LEVEL OF PAIN? ____/10

THE PAIN QUALITY IS: __BURNING __CONSTANT ___DULL __SHARP __SHOOTING __THROBBING __TINGLING __OTHER

PATIENT SIGNATURE: _____ **DATE:** _____

CAPUANO KING PODIATRY

DID YOU GET A PNEUMOCOCCAL VACCINATION? __YES __NO **FLU? __YES __NO** **COVID? __YES __NO**

HAVE YOU FALLEN WITHIN THE LAST 12 MONTHS? __ YES __NO WERE YOU INJURED FROM THE FALL? __YES __NO

ADVANCED DIRECTIVE: __LIVING WILL __ DNR __ DURABLE POWER OF ATTORNEY __SURROGATE APPOINTED __ NONE

MEDICAL HISTORY: __ ALCOHOLISM __ALLERGIES __ANXIETY DISORDER __ARTHRITIS __ASTHMA __BLOOD CLOT

__BLOOD DISORDERS __BREATHING DISORDERS __CVA __CANCER __CIRCULATION PROBLEMS __DIABETES TYPE 1/TYPE 2

__DEPRESSION __GOUT __HIV __HEART DISEASE __HEART MURMUR __HEPATITIS __HIGH BLOOD PRESSURE

__ HIGH CHOLESTEROL __ KIDNEY DISEASE __ LIVER DISEASE __ MENTAL ILLNESS __ MUSCULOSKELETAL

__NEUROPATHY (SPECIFY)_____ __SKIN DISORDERS __SLEEP APNEA __STOMACH APNEA

__STOMACH/BOWEL DISORDER __STROKE __THYROID DISEASE (SPECIFY) _____ __OTHER (SPECIFY) _____

ARE YOU PREGNANT? __YES __NO ARE YOU NURSING? __YES __NO

SURGICAL HISTORY: ___NONE __ ANGIOPLASTY __APPENDECTOMY __BYPASS __C-SECTION __CATARACTS __CHOLESYTECTOMY
HAVE YOU EVER HAD ANY SURGICAL PROCEDURES ON FOOT/ANKLE OR ANYWHERE ELSE ON YOUR BODY? __YES __N O

IF YES DESCRIBE:_____ DO YOU HAVE ANY ARTIFICIAL JOINT? __YES (WHERE? _____ __NO

DO YOU HAVE AN ARTIFICAL HEART VALVE? __YES __NO

FAMILY HISTORY: IS THERE ANY FAMILY HISTORY OF: (**BLOOD RELATIVE)** PLEASE **INDICATE FAMILY MEMBER**

__ ALZHEIMER'S	_____	__ ARTHRITIS	_____
__BLEEDING DISORDERS	_____	__ BLOOD CLOT	_____
__CANCER	_____	__ CATARACTS	_____
__ CIRCULATION DISORDERS	_____	__ DEPRESSION	_____
__ DIABETES	_____	__ EMPHYSEMA	_____
__ HEART DISEASE	_____	__ HIGH BLOOD PRESSURE	_____
__ NEUROLOGICAL	_____	__ STROKES	_____
__ THYROID DISEASE	_____	__ OTHER	_____

REVIEW OF SYSTEMS:

CARDIOVASCULAR __ LEG PAIN WHEN WALKING __FEVER __ CHEST PAIN/PRESSURE __LEG SWELLING __COLD HANDS/FEET
__VASCULAR DISEASE __VALVE PROBLEMS __FAINTING __PALPATATIONS __ NONE

GENITOURINARY __BLOOD IN URINE __ HESITANCY __ INCONTINENCE __ INCREASED URGENCY __ KIDNEY DISEASE __ KIDNEY STONES
__ EXCESSIVE URINATION__DECREASED FREQUENCY __ NONE

GASTROINTESTINAL __ABDOMINAL PAIN __HEARTBURN __BLOOD IN SSTOOL __VOMITING __ ULCERS __CONSTIPATION __ DIARRRHEA
__ TROUBLE SWALLOWING __DECREASED APPETITE __INCREASED APPETITE __NONE

INTEGUMENTARY __ATHLETE'S FOOT __ NAIL ABNORMALITIES __ KELEOIDS __ITCHINESS __DRY, SCALY SKIN __NONE

NEUROLOGICAL __TINGLING __TREMORS __ WEAKNESS __ PARALYSIS __SEIZURES __ NUMBNESS __HEADACHES __ NONE

MUSCULOSKELETAL __ BACK/NECK PAIN __SCIATICA __ JOINT STIFFNESS/ SWELLING __ JOINT/MUSCLE PAIN __ MUSCLE WEAKNESS __NONE

RESPITORY **__ CHEST PAIN __SHORTNESS OF BREATH __ WHEEZING __ EMPHYSEMA __COPD __COUGHING __ SNORING __NONE**

PATIENT SIGNATURE: _____ DATE: _____