



Patient Update Form

Last Name: _____ First: _____ MI: _____

Mailing Address: _____ Primary Care Physician: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ Gender: M F

Home Phone #: (_____) _____ Marital Status: Married Widowed Single Divorced

Cell Phone #: (_____) _____ Social Security Number #: _____-_____-_____

Preferred Method of Contact: Cell Phone Home Phone Race: _____ Hispanic/Latino? Yes No

Email: _____ EMERGENCY CONTACT

Responsible Party (Minors Only) Name: _____

Name: _____ Ph #: (_____) _____ Relation: _____

Mailing Address: _____ Pharmacy Name: _____

City: _____ State: _____ Zip: _____ Pharmacy Number: _____

Phone #: (_____) _____ Shoe Size: _____

Occupation: _____ Circle One: FT PT Retired Student

Do you smoke? Yes No In the past - How long ago? _____ Do you drink alcohol? No Yes

Do you have a living will or a surrogate decision maker? _____

Date of last flu shot? _____ Did you have a pneumonia vaccination? _____

Insurance Information:

Insurance Company: _____ Identification #: _____ Group #: _____

Allergies:		
<input type="checkbox"/> None	<input type="checkbox"/> Cortisone	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Latex	<input type="checkbox"/> Codeine	<input type="checkbox"/> Food:
<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other:

What reaction do you experience with your allergy? _____

Patient Name: _____ DOB: _____ Date: _____

New Surgeries Since Last Visit: _____

Medications (all prescription, over the counter, supplements, herbal, and vitamins)

Supply list if extra space is needed

<u>Medication</u>	<u>Dose Amount</u>	<u>How Often Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please update your Past Medical History:

- | | | |
|-------------------------------------|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Arthritis | <input type="radio"/> Heart Problems | <input type="radio"/> Liver Disease (HEP A B C) |
| <input type="radio"/> Back Problems | <input type="radio"/> High Blood Pressure | <input type="radio"/> Stomach Ulcers/Reflux |
| <input type="radio"/> Blood Clots | <input type="radio"/> HIV+/AIDS | <input type="radio"/> Stroke |
| <input type="radio"/> Depression | <input type="radio"/> Heart Disease | <input type="radio"/> Thyroid Disorder |
| <input type="radio"/> Diabetes | <input type="radio"/> High Cholesterol | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Emphysema | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Other: _____ |
| <input type="radio"/> Fibromyalgia | <input type="radio"/> Kidney Stones | |

Reason for your visit today (specify foot): _____

When did this problem start: _____ What caused it: _____

Have you seen anyone else for this (please specify)? _____

Previous Treatments include (check all that apply):

- | | | |
|---|--|--|
| <input type="radio"/> Medication: _____ | <input type="radio"/> Surgery: _____ | <input type="radio"/> Inserts/Orthotics |
| <input type="radio"/> Injection (If so, How many?
_____) | <input type="radio"/> MRI
(Date: _____) | <input type="radio"/> Brace |
| <input type="radio"/> X-rays
(Date: _____) | <input type="radio"/> CT Scan
(Date: _____) | <input type="radio"/> Cast |
| <input type="radio"/> Physical Therapy | <input type="radio"/> Ice | <input type="radio"/> Rest |
| <input type="radio"/> Antibiotics | <input type="radio"/> Stretching | <input type="radio"/> Other:

_____ |

Please provide any other information that you think will be beneficial in your treatment:

