NEW PATIENT MEDICAL INFORMATION FORM

NAME: ______________________________ BIRTHDATE: _____________________ AGE: _______

1. PLEASE EXPLAIN YOUR FOOT OR ANKLE PROBLEM.

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2. HOW WOULD YOU DESCRIBE THE PAIN OR DISCOMFORT? Check all that apply.
□ACHE □BURNING □CRAMP □DULL □ITCHY □NUMBNESS □PINS & NEEDLES □SHARP □THROBBING □TINGLING □OTHER: ____

3. HOW WOULD YOU RATE THE PAIN ON A SCALE OF 1 TO 10, 10 BEING MOST PAINFUL? ____

4. WHERE IS THE PROBLEM LOCATED? Be specific.

____

5. HOW LONG HAS THIS PROBLEM BEEN BOTHERING YOU IN TERMS OF DAYS, WEEKS, MONTHS OR YEARS? ____

6. DID YOU SUFFER A TRAUMA TO YOUR FOOT OR ANKLE? □YES □NO. IF YES, PLEASE DESCRIBE.____

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7. WHAT HAVE YOU DONE TO TREAT THE PROBLEM? HAVE YOU TAKEN ANY MEDICATIONS TO RELIEVE THE PROBLEM? WHAT MAKES THE PAIN/DISCOMFORT BETTER?____

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8. ARE YOU CURRENTLY PREGNANT? □YES □NO

9. MEDICAL HISTORY: Check all that apply.

□Anemia	**□Asthma**	**□Atrial Fibrillation**	**□Cancer _____________**
□Diabetes	**□Gout**	**□Heart Failure**	**□Hepatitis**
□High Blood Pressure	**□High Cholesterol**	**□HIV/AIDS**	**□Hypothyroidism**
□Kidney Disease	**□Mitral Valve Prolapse**	**□Neuropathy**	**□Osteoarthritis**
□Osteoporosis	**□Prostate Disorders**	**□Rheumatoid Arthritis**	**□Stroke**

□Others:____

10. MEDICATIONS: Please list all medications you take on a daily or regular basis.

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11. ALLERGIES: Check all that apply & describe the reaction to the drug in the space provided.

□Aspirin_____________	**□Codeine_____________**	**□Epinephrine_________**	**□Iodine______________**
□Latex_______________	**□Lidocaine___________**	**□Morphine____________**	**□Novocaine___________**
□Penicillin__________	**□Percocet____________**	**□Sulfa Drugs_________**	**□Tylenol_____________**
□Vicodin_____________	**□Others______________**		

12. PAST SURGERIES: Please list all surgeries you have undergone in your lifetime.

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13. FAMILY HISTORY: Please list the relationship of the family member(s) with these problems.

☐Cancer__________________________ ☐Diabetes_____________________________________

☐Heart Problems__________________ ☐Foot Problems________________________________

14. OCCUPATION: ____

15. SOCIAL HISTORY: Check all that apply.

☐Alcohol Use ☐Caffeine Use ☐Drug Use ☐Tobacco Use ☐Exercise Habits_______________________

16. HEIGHT: __________ WEIGHT: __________ SHOE SIZE __________

REVIEW OF SYSTEMS

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

ENDOCRINE: ☐**Excessive Thirst** ☐**Fainting** ☐**Frequent Urination** ☐**Sudden Weight Gain or Loss**

SKIN: ☐**Athlete's Foot** ☐**Eczema** ☐**Growth** ☐**Rash** ☐**Skin Cancer** ☐**Skin Color Changes** ☐**Skin Infections/Cellulitis** ☐**Slow Healing Wounds** ☐**Sunburn Easily** ☐**Toenail Color Changes or Deformity**

MUSCULOSKELETAL: ☐**Fracture (Prior)** ☐**Joint Pain** ☐**Loss of Coordination** ☐**Muscle Aches** ☐**Muscle Spasms** ☐**Muscle Weakness**

GASTROINTESTINAL: ☐**Abdominal Pain** ☐**Blood in Stool or Urine** ☐**Constipation** ☐**Decrease in Appetite** ☐**Diarrhea** ☐**Stomach or Intestinal Ulcers**

NEUROLOGICAL: ☐**Change or Loss of Sensation in Extremities** ☐**Seizures** ☐**Tremors**

CARDIOVASCULAR: ☐**Blood Clots** ☐**Calf Pain at Rest or with Walking** ☐**Swollen Legs/Feet**

PSYCHIATRIC: ☐**Anxiety** ☐**Depression** ☐**Memory Loss** ☐**Mood Swings** ☐**Nervousness** ☐**Stress** ☐**Suicidal Tendencies**

CONSTITUTIONAL: ☐**Fever** ☐**Chills** ☐**Nausea** ☐**Vomitting**

SURVEY

HOW DID YOU HEAR ABOUT DR. REYES? Please check all that apply.

☐Doctor or Healthcare Provider____

☐Family Member or Friend____

☐Internet Search Engine: ☐AOL ☐Bing ☐Google

☐Other:______________________________

☐Newspaper: ☐Hartford Courant ☐Voices

☐Phonebook: ☐AT&T ☐Heritage Village ☐Yellowbook

☐Website: ☐DRODINREYES.com ☐Noveon laser.com