CAROLINA PODIATRY CENTER
PATIENT INTAKE HISTORY

Name: _____ Date of birth: ___/___/___ Today's Date:___/___/___
Address: _____ Phone # _____ SS# _____
Referred By: _____ What would you like to be called: _____
Why are you seeing the doctor today: _____
_____
Injury date (if applicable) _____
Height _____ **Weight** _____ **Shoe size** _____ width _____ (narrow/wide)
Family Physician: _____

Do you have diabetes? ____ yes ____ no (if yes) Type I or **Type II**
How long? _____
Do you take insulin? ____ yes ____ no
How much do you take and when? _____

Have you had any operations? ____ yes ____no
List When/Where _____
_____
Pharmacy Name, Location and Phone number: _____
List Medication you take regularly (over the counter medications/vitamins/homeopathic)
Include dosage & frequency
_____
_____
_____
_____
_____

IF YOU HAVE (HAD) ANY OF THE FOLLOWING, PLEASE CHECK:

Heart Trouble ___	Kidney Trouble ___	High Blood Pressure ___
Liver Trouble ___	Asthma ___	Lung Trouble ___
Stroke ___	Stomach Ulcers ___	Circulation disease (PVD) ___
Rheumatic Fever ___	Tuberculosis ___	Broken Bones (Foot/leg) ___
Anemia ___	Arthritis ___ type _____	Varicose Veins ___
Phlebitis ___	Artificial Joint ___	Cancer ___
Gout ___	Seizures ___	Epilepsy ___
Artificial Heart Valve ___	AIDS or other Immunosuppressive Disorders ___	hepatitis ____

Other health related issues for which you are taking medication for _____

ARE YOU ALLERGIC OR SENSITIVE TO:
Penicillin ___ Aspirin ___ Novocain ___ Codeine ___ Anesthetics ___ Iodine ___ Adhesive tape ___
Drugs ___ what and explain reaction _____
Other ___ what and explain reaction _____

Do you smoke? ___ yes ___ no packs/day _____ How long? _____
Do you drink alcohol? ___ yes ___ no
(Women) Do you suspect that you are pregnant? ____ yes ____ no Are you nursing? ___ yes ___ no

Signature _____ **date** _____