CAROLINA PODIATRY CENTER
PATIENT INTAKE HISTORY

Name: _____ Date of birth: _____/_____/_____ Age: _____
Address: _____
Referred by: _____ What would you like to be called? _____
Why are you seeing the doctor today *(be specific as possible)*: _____
_____
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

Have you had any operations? _____ yes _____ no
List what the procedure was and when it was performed:
_____
_____

Pharmacy Name, Location, & Phone number: _____
List Medications you take regularly (include 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 Immunosuppresive Disorders ____ hepatitis ____
Other health related issues for which you are taking medication: _____

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 average intake per week: _____
(Women) Do you suspect that you are pregnant? __ yes __ no Are you nursing? __ yes __ no

Signature _____ **date** _____