North Shore Podiatry, PC
535 Plandome Rd #2
Manhasset, NY 11030
T: 516.365.5544 / F: 516.365.5545

Date: ___/____/____

Patient Name: ________________________________ DATE of Birth: ___/___/___ Age: ___ Sex: M F

Home Address: ______________________________ City/State: ___________________ Zip: __________

May we leave a message?

Home Phone #: (____) ______-______ Yes No

Work Phone #: (____) ______-______ Yes No

Cell Phone #: (____) ______-______ YES No Text? yes or no

E-mail: ____________________________ Yes No

Primary Language: ____________________

RACE: _________ Ethnicity: ☐ Hispanic or Latino ☐ not Hispanic or Latino ☐ decline

Emergency Contact: ____________________RELATIONSHIP: __________ Phone #: (____) ____-______

Primary Care Doctor: _________________________________ Phone: ___________________________

Date of Last visit with Primary care doctor: _________________________________

Have you ever seen a podiatrist before? if so, when? Date: ________________________________

Pharmacy: ______________________ Location: ____________________ Phone #: (____)
____-______

Is there a family member or other person you would like for us to share your medical information?

_____ Yes Name(s)
____

_____ No

Who Referred You To US? ____

Patient consent for prescription history = Please Check ONE:

__Patient gives consent to retrieve prescription history when request is triggered
__Patient **Does Not** consent to retrieve prescription history when request is triggered

Dr. Lauren A. Schwartz – Dr. Jillian Irwin – Dr Lisa Fuchs - Dr. Lina Dobronevsky

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NAME: ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE? REASON

____
____
____
____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

____
____
____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

____
____
____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL:

☐ CURRENT: TYPE ____________________ FREQUENCY: ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

EMPLOYER: ______________________________ OCCUPATION: ______________________________

HOW MUCH ARE YOU ON YOUR FEET ON A DAILY BASIS? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER: ________________________________

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Name: ___________________________

Height: ____________ Weight: ____________ Blood pressure: ________________ Shoe size: __________

Allergies: ☐ Medications ____
☐ None ☐ Other ____

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Other Conditions:								

Current Problem

What specific problem brings you to our office today? ____

How long ago did this problem first start? _________ days / weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other ____

How would you rate your pain on a scale from 0 to 10? (please circle)
(No pain) 0 1 2 3 4 5 6 7 8 9 10
(Worst pain possible)

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ other ____

What makes your pain or problem feel better? ____

What treatments have you had for this problem? ____

How has this problem affected your lifestyle or ability to work? __________________________________

Was this problem caused by an injury? ☐ No ☐ Yes (describe) _________________________________
If yes, was it a work-related injury? ☐ No ☐ Yes (describe) __________________________________

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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

POLICY #: ____________________ EFFECTIVE DATE ___________

SECONDARY INSURANCE COMPANY NAME: ____

POLICY #: ____________________ EFFECTIVE DATE ___________

- TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.
- I HEREBY GIVE CONSENT TO NORTH SHORE PODIATRY P.C, AND ALL HEALTHCARE PROVIDERS FURNISHING CARE ASSOCIATED WITH THIS FACILITY TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

____ ____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

____ ____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

____
SIGNATURE

____
DATE