

Name:

DOB:

Peter M. Wilusz, D.P.M.

Town Center Foot and Ankle

(please print)

TODAY'S DATE _____

LAST NAME _____ FIRST _____ MI _____

BIRTHDATE _____ S.S. # _____

SEX (PLEASE CIRCLE): Male Female

MARITAL STATUS: M S D W

ADDRESS _____
(Street) (City) (State) (Zip Code)

HOME PHONE# _____ ALT. PHONE # _____

EMAIL _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE # _____ INSURANCE _____

SUBSCRIBER'S NAME _____ BIRTHDATE _____

RELATIONSHIP TO SUBSCRIBER _____ EMPLOYER _____

EMERGENCY CONTACT _____
(Name) (Relationship) (Phone)

HOW WERE YOU REFERRED TO OUR OFFICE? (PLEASE CIRCLE): DOCTOR ▪ FRIEND ▪ FAMILY MEMBER ▪ ONLINE ▪
YELLOW PAGES ▪ CLOSE TO HOME/WORK ▪ INSURANCE PLAN ▪ HOSPITAL ▪ OTHER _____
(Please specify name of reference)

FAMILY PHYSICIAN: _____
(Name) (Phone Number)

OTHER PHYSICIAN(S): _____
(eg: heart &/or vascular) (Name) (Phone Number)

(Name) (Phone Number)

PHARMACY: _____
(Name) (Location) (Phone Number)

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Peter M. Wilusz, D.P.M., or insurance company to release any information required to process my claims.

Patient/Guardian

Signature _____ Date _____

Name:

DOB:

MEDICAL HISTORY

| | |
|----------------------------------|--|
| CC: | |
| HPI: | |
| Location | |
| Quality | |
| Severity | |
| Duration | |
| Timing | |
| Context | |
| Modifying factors | |
| Associated signs/symptoms | |
| BP: | |
| HR: | |
| RR: | |
| T: | |
| This section for office use only | |

INDICATE WHETHER YOU HAVE ANY OF THE FOLLOWING:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Diabetes Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bowel disorder | <input type="checkbox"/> Cancer history |
| <input type="checkbox"/> Hypertension/High BP | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> GI/Rectal bleeding | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Night Cramps | <input type="checkbox"/> Acid reflux (GERD) | <input type="checkbox"/> Congenital Nerve Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Leg Pain with Activity | <input type="checkbox"/> Headaches | Other: _____ |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Eye problems | _____ |
| <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problems | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Dry mouth, eyes | _____ |
| <input type="checkbox"/> Psychiatric conditions Specify: _____ | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy | _____ |
| <input type="checkbox"/> Arthritis Type: _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease | _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney problems | _____ |
| | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bladder problems | |
| | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Prostate problems | |
| | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Venereal disease | |

Please list all past surgeries, injuries, hospitalizations with date of occurrence:: _____

Have you ever had an adverse reaction to anesthesia? No Yes; If yes, please explain: _____

MEDICATIONS:

| Name | Dose/ Strength | Route | Frequency |
|------|----------------|-------|-----------|
| | | | |
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| | | | |

ALLERGIES:

| Allergy | Reaction |
|---------|----------|
| | |
| | |
| | |

Name:

DOB:

General Health and Social History:

Primary Care Physician: _____ Date of last visit: _____

Age: _____ Current weight: _____ Height: _____ Shoe Size: _____

Do you have pain in any of these areas: Back Neck Hip Knee Shoulders Elbow Wrist

Do you currently smoke or have a history of smoking? Yes No Socially Quit
If yes, describe: _____ Pack(s) Per day week month For _____ Years
Date Quit: _____

Alcohol Usage: Y N Type: _____ Amount: _____ Frequency: _____

Do you now or have you ever used recreational drugs? Y N If yes, describe: _____

Hepatitis A B C N/A HIV Status: _____

Do you exercise? Y N Type: _____ Amount: _____ Frequency: _____

How would you describe your stress level? Low Moderate High

Please list any specific family medical history you are aware of (diabetes, heart disease, cancers, etc):

| <u>Relation</u> | <u>Disease</u> |
|-----------------|----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I hereby consent and give permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures on me as the doctor deems necessary.

Patient/Guardian
Signature _____ Date _____