## Peter M. Wilusz, D.P.M. Town Center Foot and Ankle

DATE:					
	PERSONAL INFORMA	ATION			
FIRST NAME:	LAST NA	ME:	MI:		
BIRTHDATE: SS	N: MARI	TAL STATUS (	circle): M S D W		
SEX (circle): M F					
PHONE NUMBER: H:	C:	_ W:			
ADDRESS:	(city)		(state) (zip code)		
(street)					
EMAIL:		DIABETIC?	IF SO, TYPE?		
EMERGENCY CONTACT:(nam		(relationship)	(phone)		
HOW WERE YOU REFERRED T	O OUR OFFICE?				
PRIMARY CARE PHYSICIAN: _	(name) (pho	DA	TE OF LAST VISIT:		
PHARMACY:		me)			
(name)	(location)	(n	umber)		
	DEMOGRAPHIO	cs			
ETHNICITY (circle one): HISPANIC/LATINO or NOT HISPANIC/LATINO or DECLINED LANGUAGE SPOKEN AT HOME:					
RACE (circle one): WHITE or	BLACK/AFRICAN AMERIC HER PACIFIC ISLANDER of	AN or ASIAN r ALASKA N	or AMERICAN INDIAN ATIVE or DECLINED		
*The above information is true to the physician. I understand that I am final insurance company to release any info	ncially responsible for any balanc	e. I also authorize	enefits to be paid directly to the Peter M. Wilusz, D.P. M., or		
* I hereby consent and give permissio treatment.	n to the doctor to evaluate the pr	esenting conditio	n and suggest/provide appropriate		
Patient/Guardian Signature			Oate:		

## GENERAL HEALTH & SOCIAL HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:  ANGINA ARRHYTHMIA BACK PROBLEMS  ANEMIA ASTHMA BRONCHITIS  COPD  BLADDER PROBLEMS CONGENTIAL NERVE  CANCER HISTORY DISORDER  CHAPTYSEMA EPILEPSY EVER PROBLEMS  GOUT HEADACHES HEART DISEASE  HIATAL HERNIA HYPOTENSION LIVER DISEASE  LEG PAIN WITH ACTIVITY POOR CIRCULATION PSYCHIATRIC CONDITIONS  SHORTNESS OF BREATH SWELLING  STROKE TUBERCULOSIS  VALVULAR HEART DISEASE WEIGHT CASIN  VALVULAR HEART DISEASE WEIGHT LOSS  VENEREAL DISEASE  VENEREAL	
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THER ALLERGIES:	
URRENT MEDICATIONS: STRENGTH: DOSAGE: FREQUENCY:	

MOTHER:FATHER:				
MATERNAL GRANDMOTHER:PATERNAL GRANDMOTHER:	PATERNAL GRANDMOTHER:			
MATERNAL GRANDFATHER:PATERNAL GRANDFATHER:				
DO YOU EXERCISE? YES NO IF SO, HOW MANY MINUTES PER SESSION? TYPE OF EXERCISE: FREQUENCY: DAY MONTH				
STRESS LEVEL (circle): LOW MODERATE HIGH				
PAIN (circle): BACK ANKLE GENERALIZED NECK HIP KNEE SHOULDER ELBOW	WRIST			
SMOKING STATUS (circle): CURRENT EVERYDAY SMOKER CURRENT SOME DAY SMOKER FORMER SMOKER NEVER SMOKER	2			
ALCOHOL USAGE (circle): YES NO TYPE: BEER WINE LIQUOR AMOUNT (# of drinks) PER DAY WEEK MONTH YEAR				
DRUG USAGE (circle): YES NO IF YES, DRUG OF CHOICE:				

FAMILY MEDICAL HISTORY/DISEASES: