# *Peter M. Wilusz, D.P.M.*

*Town Center Foot and Ankle*

**DATE:**_____

**PERSONAL INFORMATION**

**FIRST NAME:**_____ **LAST NAME:** _____ **MI:**____

**BIRTHDATE:** _____ **SSN:** _____ **MARITAL STATUS** (circle): M S D W

**SEX** (circle): M F

**PHONE NUMBER:** H:_____ C:_____ W:_____

**ADDRESS:** _____
(street) (city) (state) (zip code)

**EMAIL:** _____ **ARE YOU A DIABETIC?** _____ **IF SO, TYPE?** _____

**EMERGENCY CONTACT:** _____
(name) (relationship) (phone)

**HOW WERE YOU REFERRED TO OUR OFFICE?** _____

**PRIMARY CARE PHYSICIAN:** _____ **DATE OF LAST VISIT:**_____
(name) (phone)

**PHARMACY:** _____
(name) (location) (number)

**DEMOGRAPHICS**

**ETHNICITY** (circle one): HISPANIC/LATINO or NOT HISPANIC/LATINO or DECLINED
**LANGUAGE SPOKEN AT HOME:** _____
**RACE** (circle one): WHITE or BLACK/AFRICAN AMERICAN or ASIAN or AMERICAN INDIAN
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER or ALASKA NATIVE or DECLINED

*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.

* I hereby consent and give permission to the doctor to evaluate the presenting condition and suggest/provide appropriate treatment.

**Patient/Guardian Signature** _____ **Date:** _____

## GENERAL HEALTH & SOCIAL HISTORY

**CURRENT WEIGHT:** _____ **HEIGHT:** _____ **SHOE SIZE:** _____

**PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:**

| | | |
|---|---|---|
| ANGINA | ARRHYTHMIA | BACK PROBLEMS |
| ANEMIA | ASTHMA | BRONCHITIS |
| ARTIFICIAL IMPLANT | BOWEL DISORDER | COPD |
| BLADDER PROBLEMS | CONGENTIAL NERVE | DRY MOUTH/EYES |
| CANCER HISTORY | DISORDER | EYE PROBLEMS |
| DIABETES TYPE 1 | DIABETES TYPE 2 | GI/RECTAL BLEEDING |
| EMPHYSEMA | EPILEPSY | HEARING PROBLEMS |
| FAINTING | FOOT/LEG CRAMPS | HEMOPHILIA |
| GOUT | HEADACHES | HYPERLIPIDEMIA |
| HEART ATTACK | HEART DISEASE | KIDNEY PROBLEMS |
| HIATAL HERNIA | HYPOTENSION | NEUROPATHY |
| HYPERTENSION | LIVER DISEASE | PROSTATE PROBLEMS |
| LEG PAIN WITH ACTIVITY | POOR CIRCULATION | RASH |
| NIGHT CRAMPS | RADIATION | STOMACH PROBLEMS |
| PSYCHIATRIC CONDITIONS | SINUS PROBLEMS | SWOLLEN GLANDS |
| SHORTNESS OF BREATH | SWELLING | ULCERS |
| STROKE | TUBERCULOSIS | VENEREAL DISEASE |
| THYROID DISEASE | VARICOSE VEINS | |
| VALVULAR HEART DISEASE | WEIGHT LOSS | |
| WEIGHT GAIN | ACID REFLUX | |
| LUNG DISEASE | ARTHRITIS (type) _____ | |

**HEPATITIS** (circle): YES NO **HIV STATUS** (circle): POSITIVE NEGATIVE UNKNOWN

**PAST INJURIES & DATES:** _____

**PAST SURGERIES & DATES:** _____

**ANY ADVERSE REACTIONS TO ANESTHESIA?** _____ **IF SO, WHAT HAPPENED?** _____

| **MEDICATION ALLERGIES:** | **REACTION:** | **DEGREE OF SEVERITY** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**OTHER ALLERGIES:** _____

| **CURRENT MEDICATIONS:** | **STRENGTH:** | **DOSAGE:** | **FREQUENCY:** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**FAMILY MEDICAL HISTORY/DISEASES:**

**MOTHER:** _____ **FATHER:** _____

**MATERNAL 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 WEEK

**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

**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:** _____