WELCOME TO DR. KAPLAN'S OFFICE

TODAY'S DATE _ _ /_ _ / _ _

Last Name	First Name	Date of Birth / / Sex M F
Address	Town	Zip Code
Home Phone #	Cell Phone #	S.S. #
Pharmacy	Pharmacy Address	
Place of Employment		Occupation
Where did you hear about Dr. Kaplan?		Doctor/ Internist
Have you had previous treatment by a Podiatrist?		When?
My chief complaint is:		
How long have you had the complaint?		Which Foot? Right Left Both
If painful, circle what makes pain worse:	Walking Siting Shoes Standing First step out of bed	

COMPREHENSIVE PATIENT MEDICAL HISTORY

DIAGNOSED OR CURRENTLY TREATED OR PAST TREATED FOR:

□ Diabetes	□ Heart Attack	□ High blood pressure
□ Anemia	□ Raynaud disease	□ Heart condition
□ Stroke	□ Poor circulation	□ Eye problems
□ Gout	□ Kidney disease	□ Keloid/ thick scar
□ Sciatica	□ Osteoporosis	□ Alzheimer's
□ Arthritis	□ Lyme's disease	□ Hearing/ ear problem
□ Epilepsy	□ Headaches	□ Psychiatric disorder
□ Asthma	□ Nerve disorder	□ Tuberculosis
□ Hepatitis	□ Lung disorder	□ Thyroid problem
□ Urine problem	□ Liver disease	□ Bowel issues
□ Cancer	□ HIV positive	□ Other: List
□ Hypercholesterolemia	□ Stomach ulcer	□ **NONE OF THESE**

LIST OF ALLERGIES - SKIN OR OTHER SEVERE REACTION

Allergy to …	Yes	No	If yes, what happens?
Penicillin	□	□	
Other antibiotic	□	□	
Aspirin, advil, aleve	□	□	
Latex	□	□	
Novocaine	□	□	
Sulfa	□	□	
Adhesive tape	□	□	
Pain medicine	□	□	
Shrimp, iodine	□	□	
Tylenol	□	□	
List others	□	□	

IMMUNIZATIONS

Vaccine	Yes	No
Flu/influenza	□	□
Tetanus	□	□
Shingles	□	□
Pneumococcal	□	□

If Yes, what month/ year was the vaccination?

If unsure, check No

ADDITIONAL QUESTIONS

	Yes	No
Leg/ heart vascular grafts	□	□
Do you have joint implants	□	□
Current/past serious illness	□	□
Have you had any surgery	□	□
Are you currently pregnant	□	□
Are you slow to heal	□	□
Any abnormal bleeding	□	□
Do you take blood thinners	□	□
Do you smoke now	□	□
Did you smoke in the past	□	□
Ready to quit smoking	□	□

LIST OF MEDICATIONS (IF MORE SPACE NEEDED WRITE ON BACK, PLEASE INDICATE)

Medicine	Treatment for

PAST SURGICAL HISTORY/ HOSPITALIZATIONS (Year of surgery)

FAMILY MEMBERS WHO HAVE HAD (i.e. Mother, Father, Grandparent)

Arthritis	Foot problems
Stroke	Gout
Cancer	Heart attack
Diabetes	High blood pressure

DIABETIC ADDITIONAL INFORMATION

Do you have…	Yes	No	
Diabetes	□	□	_ _ _ _ (year diagnosed)
Peripheral neuropathy	□	□	
Peripheral arterial disease	□	□	(list any catherizations, bypass)

HgA1c % & date taken _ . _ % _ _ / _ _ / _ _ (approximate if unknown)

Average FBG _ _ _ M.D./D.O. who is treating/ managing your Diabetes? Dr.

About how much do/ did you smoke a day (i.e. half a pack, 1 pack)? approximately packs per day ; approximately smoking years

Previous treatment (nicotine replacement, self, etc)?

Height _ ' _ _ "

Alcoholic Beverages? None Rare Moderately Daily

Weight lbs