New Patient Registration

Chart Number: ________________ **Date:** ___________________

First Name: _____________________ **Last Name:** ______________________ **Middle Initial:** ______

Date of Birth: ____/_____/______ **Primary Phone Number**: ______________________________

Gender: ________________________ **Preferred Pronouns:** He or She or They **(Please circle one)**

Marital Status: _______________________ **Email:** ____

Emergency Contact: ______________________________ **Emergency Contact Number:** ________________

Primary Care Physician: ______________________________________

Are you a smoker? Yes or No **If you quit, when?** _____________ **How much do you smoke?** _________

What is your weight? ___________ **What is your height** _________ **What is your shoes size?** _________

Have YOU ever had or have been treated for any of the following?

	Y	N			Y	N
Alzheimer's				**Hepatitis A B C**		
Anemia				**High Blood Pressure**		
Arthritis				**HIV/Aids**		
Asthma				**High Cholesterol**		
Bleeding Disorder				**Kidney Disease**		
Cancer				**Liver Disease**		
Circulatory Disorder				**Parkinson's**		
Diabetes Type 1				**Phlebitis**		
Diabetes Type 2				**Skin Disease**		
Epilepsy				**Stomach Ulcer**		
Gout				**Stroke**		
Heart Attack/Failure				**Thyroid Disease**		
Heart Disease/A fib				**Vascular Disease**		
If we missed something, please list it here:						

Please explain the main problems you are having with your feet: __________________________________
____
____

Please List ANY and ALL Surgeries:

____
____

Please List Any Allergies:

____
____

(See Back)

What is your Primary Pharmacy? ____

Are you currently taking any medications?   Y or N

Please list any medications you are taking below:

____

____

____

____

____

____

____

Does/did your immediate family members have any of the following?	Yes:	Relationship: (Father/Mother/Brother/Sister)	Deceased: (Y or N)
Anemia			
Alzheimer's			
Arthritis			
Asthma			
Bleeding Disorder			
Cancer			
Circulatory Disorder			
Diabetes			
Dementia			
Epilepsy			
Gout			
Heart Attack/Failure			
Heart Disease/A fib			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Parkinson's			
Skin Disease			
Stomach Ulcer			
Stroke			
Thyroid Disease			
Vascular Disease			