Demographics/Insurance (**All Information Given Here is Confidential**)

Name: _____ Age _____ Gender _____

Date of Birth: _____ [] Single [] Married [] Widowed [] Divorced

Address: _____

City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone_____

E-mail:_____

My preference for contact (Choose one) via [] Home Phone [] Cell Phone [] Work Phone

[ ] I give permission to leave Voice Mails regarding any medical tests on my
[ ]Home Phone Answering machine [ ] Cell Phone.

Ethnicity: Hispanic Non-Hispanic other [ ] Decline
Race: (Caucasian, African America) other_____ [ ] Decline
What is your Foot Problem(brief)? _____

Primary Care Physician/Pediatrician_____

Work Location: _____

The Following people may Access my Chart

Name	**Relationship (spouse, child, other)**
_____	_____
_____	_____
_____	_____
_____	_____

Initial_____ Date_____

>>>>>>>> Continue on next Page <<<<<<<<

Patient Medical History
Date:_____ Patient Name: _____ DOB _____

Personal Habits:
Current Smoker(circle one): Yes No Cigarettes/day____ #Years smoking___
Prev Smoker**(**circle one**): Yes No #Years smoking_____**

Any Other Forms of Tobacco usage? Vaping?_____ Years usage_____
Smokeless Tobacco/Chew? Currently using?____Years usage/used_____
Alcohol use: (circle one) None Occasional Moderate Heavy

Caffeine: None Occasional Moderate Heavy

Illicit Drug use: _____

Have you ever ABUSED any OTC or Prescription Drugs? [ ] Yes [ ] No
Medication name_____

*******DIABETICS ONLY*******
When was your last **Diabetic** Eye Exam? _____By Whom?_____
When was your last Diabetic A1c performed? _____

Medications (Dosage, How Often) Prescription and OTC			**Allergies** [ ] No Known Drug Allergies	**Reaction**
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

- [] Additional Meds, Use the back page *

OFFICE USE ONLY

Height	Weight	Blood Pressure	Pulse	Temperature

Date_____ Name _____ DOB_____

Past Illnesses:

Alcoholism	Myself Mom Dad Other_____	Lung Disease	Myself Mom Dad Other_____		
Atrial Fibrillation	Myself Mom Dad Other_____	Mental Illness	Myself Mom Dad Other_____		
Anemia	Myself Mom Dad Other_____	Muscular Sclerosis	Myself Mom Dad Other_____		
Asthma	Myself Mom Dad Other_____	Osteoarthritis	Myself Mom Dad Other_____		
Cancer/Tumor	Myself Mom Dad Other_____	Osteoporosis	Myself Mom Dad Other_____		
Diabetes	Myself Mom Dad Other_____	Phlebitis	Myself Mom Dad Other_____		
Drug Abuse	Myself Mom Dad Other_____	Rheumatoid Arthritis	Myself Mom Dad Other_____		
Depression	Myself Mom Dad Other_____	Stroke	Myself Mom Dad Other_____		
Epilepsy/Seizure	Myself Mom Dad Other_____	Suicide Attempt	Myself Mom Dad Other_____		
Glaucoma	Myself Mom Dad Other_____	Thyroid Disease	Myself Mom Dad Other_____		
Factor V Leiden	Myself Mom Dad Other_____	Tuberculosis	Myself Mom Dad Other_____		
Heart Disease	Myself Mom Dad Other_____	Ulcer in GI tract	Myself Mom Dad Other_____		
High Blood Pressure	Myself Mom Dad Other_____	Venereal Disease	Myself Mom Dad Other_____		
Kidney Disease	Myself Mom Dad Other_____	High Cholesterol	Myself Mom Dad Other_____		
Liver Disease	Myself Mom Dad Other_____	HIV/Immune Dx	Myself Mom Dad Other_____		
Hepatitis	Myself Mom Dad Other_____	Other_____	Myself Mom Dad Other_____		

Past Surgical History

_____

_____

_____

Review of systems As they relate to your health

Constitutional		**ENDOCRINE**		**ALLERGIC/IMMUNE**	
Weight Loss	Y	Loss of Hair	Y	Hives/Eczema	Y
Fatigue	Y	Heat/Cold intolerance	Y	Hay Fever	Y
Fever	Y	**Respiratory**		**PSYCHIATRIC**	
EYES		Cough	Y	Anxiety	Y
Glasses/Contacts	Y	Coughing Blood	Y	Depression	Y
Eye Pain	Y	Wheezing	Y	Mood Swings	Y
Double Vision	Y	Chills	Y	Difficulty Sleeping	Y
Have Cataracts	Y	**GASTROINTESTINAL**		**HEMATOLOGY**	
EAR,NOSE,THROAT		Heartburn/Reflux	Y	Easy bruising	Y
Difficulty Hearing	Y	Nausea/Vomiting	Y	Gums Bleed Easily	Y
Ringing in Ears	Y	Constipation	Y	Enlarged Glands	Y
Vertigo	Y	Change in BMs	Y	**MUSCULOSKELETAL**	
Sinus Trouble	Y	Diarrhea	Y	Joint Pain/Swelling	Y
Nasal Stuffiness	Y	Jaundice	Y	Stiffness	Y
Frequent Sore Throat	Y	Abdominal Pain	Y	Muscle Pain	Y
CardioVascular		Black or Blood BM	Y	Back Pain	Y
murmur	Y	**GENITOURINARY**		**SKIN**	
Chest Pain	Y	Burning/Frequency	Y	Rash/Sores	Y
Palpitations	Y	Nighttime	Y	Lesions	Y
Dizziness	Y	Blood in Urine	Y	Itching Burning	Y
Fainting Spells	Y	Erectile Dyfunction	Y	**NEUROLOGICAL**	
Shortness of Breath	Y	Abnormal Discharge	Y	Loss of Strength	Y
Difficulty lying Flat	Y	Bladder Leakage	Y	Numbness	Y
Swelling Ankles	Y			Headaches	Y
				Tremors	Y
				Memory Loss	Y

Date _____ Name _____ DOB _____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for LAWRENCE S HAN DPM

Signed_____ Date:_____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

- I authorize LAWRENCE S HAN DPM to release medical information required to process my claim

Signed_____ Date:_____

- I have read and understand the Financial Policy for LAWRENCE S HAN DPM

Signed_____ Date:_____

- I authorize LAWRENCE S HAN DPM to obtain/have access to my medication history

Signed_____ Date:_____

- I authorize my provider's office to contact me by mobile phone

Signed_____ Date:_____