McDuffie Podiatry and Wound Care, PC

(please fill in all spaces so we may complete your medical record)

Patient First Name_____Middle Name_____

Patient Last Name_____Sr,Jr.II. III_____SS #_____

Gender: (circle one) male female date of birth _____

Street address _____ PO Box_____

City_____ State_____ Zip_____

Home phone_____work phone_____ cell phone_____

Email address_____

Ethnicity: check one: _____ Hispanic or Latino _____Non-Hispanic or Latino Language_____

Race_____ Employment (circle one) Employed retired disabled student

Marital Status: (circle one) Married Single Widowed Divorced

Employer_____ Employer phone #_____

Who referred you to our office?_____

Do we have your permission to receive your medication history from pharmacy: _____yes _____ no

Primary Physician (who you see if you are sick)_____

Emergency Contact_____Emergency contact phone #_____

How would you like to be contacted: phone _____ email _____

Who can we speak to when we call you: _____patient only_____patient's spouse _____anyone answering phone

Name of your drug store_____Phone # _____

Name of your spouse_____Spouse's phone #_____

Spouse's employer_____Spouse employer phone #_____

Signature Patient_____date_____

Signature Responsible Party_____SS#_____

Responsible party date of birth_____ Phone # _____date_____

**Our practice does not bill patients for the balance due. Payment is due at time of service. Your co-payment and deductible is due at time of service.*

NEW PATIENT MEDICAL INFORMATION

Patient Name_____Date of Birth_____

Are you allergic to any medications:_____

_____

What medications do you presently take:_____

_____

_____

What medical conditions do you presently have:_____

_____

_____

List any medical conditions that your family members presently have or have had previously: (diabetes, heart disease, kidney disease, cancer, heart attack, high blood pressure, high cholesterol, depression, or any others not listed).

Mother:_____

Father: _____

What are you seeing the Dr. for today:_____

_____

What have you done to correct the problem:_____

_____

Previous surgeries & dates:_____

_____

Previous/ recent injuries:_____

Where and when did you have injury_____

Please rate your pain level (circle one): none mild moderate severe

Location of pain_____when did pain start_____

Do you have acid reflux	yes	no	Do you drink alcohol	yes	no
Do you have stomach ulcer	yes	no	Are you on dialysis	yes	no
			Kidney transplant	yes	no

Who do you live with:

How many Children: #

Occupation (current or former):

Do you smoke: Current every day smoker Former smoker Never smoked

How much do you smoke per day?

Do you drink caffeinated beverages (cola, coffee, or tea)? yes no

Number per day:

Have you had a fall in the past 12 months yes no if yes how many _____

Have you had a flu shot this year yes no

Have you had a pneumonia shot yes no

Do you have a living will yes no

Do you have someone who takes care of your healthcare information yes no

If yes please tell us their name:_____

What is your shoe size_____ Height _____ Weight _____