

**BOSTON COMMON PODIATRY, INC.
WELCOME**

Patient Name: _____ **Date:** _____
DOB: ___/___/___ **Age:** ___ **Height:** _____ **Weight:** _____ **Shoe Size:** ___
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone:** _____
Occupation: _____
Primary Care Physician: _____ **Phone:** _____
Date last seen by PCP: _____
Pharmacy: _____ **Phone:** _____
Whom may we thank for referring you? _____
Primary reason for visit: _____
Duration of problem: _____
What helps/makes it worse? _____
Is it limiting your desire activity level? _____
Secondary problem(if there is one): _____
Please list any drug allergies: _____
If there are any, what happens? _____
Medications: _____

Tobacco use: Yes/No **Alcohol use:** Yes/No **Recreational drug use:** Yes/No

Medical History(please circle all that apply)

Stroke	Phlebitis	Anemia	Diabetes
Gout	Sciatica	Arthritis	Epilepsy
Asthma	Hepatitis	Dark Urine	Cancer
Heart Attack	Vascular disease	Poor circulation	Kidney disease
Osteoporosis	Lyme's disease	Headaches	Nerve disorder
Lung disease	Liver disease	Light stool	Stomach ulcer
Hypertension	Heart disease	Eye condition	Keloid/thick scar
Alzheimers	Rheumatic fever	Hearing disorder	Pyschiatric disorder
Tuberculosis	Thyroid problem	Weight loss/gain	None of the these

What surgeries have you had? _____

Hospitalizations other than for surgery: _____

of childbirths _____

Trauma/accidents: _____

Family History(if so please indicate relationship)

Diabetes _____ Stroke _____ Cancer _____ Arthritis _____ Heart attack _____ HTN _____

CONSENT FOR TREATMENT

To the best of my knowledge, the above information is correct. I hereby give my permission to Boson Common Podiatry, Inc. and it's physicians, to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature of Patient/Guardian _____