KITSA PODIATRY
Foot & Ankle Specialists

Patient Registration Form

PLEASE COMPLETE THIS FORM, THEN PRINT A COPY AND BRING IT TO US. THANK YOU!

Legal Name (Last): First: MI: Ethnicity:

◯ Single ◯ Married/Partner ◯ Widowed ◯ Other Race:

Preferred name (nickname): SSN

Age Date of birth (MM/DD/YYYY) ◯ Male ◯ Female Referred by

Mailing addr. Primary care doctor

City State Zip Code Pharmacy

Day phone # Phone type Email

Alt. phone # Phone type Allow messages to be left:

Employer Name Employment status

Employer phone

Emer. Contact Relationship Phone Number

For minor patient: legal guardian Phone Number

Please bring your insurance cards to your appointment.

Primary insurance co. **Secondary insurance co.**

Primary ins. ID number Group #

Subscriber's full name SSN Date of birth

Party responsible for acct Phone Number

Responsible party address

City State Zip Code

Last name:

1. ALLERGIES *Type in or select from list.* **No known drug allergies** ☐

Medications | Foods | Environmental

2. MEDICATIONS *If you have more than can be listed, please provide your own list to be copied.*

Med. #1		Dose		# times/day	
Med. #2		Dose		# times/day	
Med. #3		Dose		# times/day	
Med. #4		Dose		# times/day	
Med. #5		Dose		# times/day	
Med. #6		Dose		# times/day	
Blood thinner? ◯ Yes ◯ No	Type	Dose		# times/day	

Vitamins/Herbs/Supplements:

3. HEALTH AND LIFESTYLE HISTORY *Please check any that apply.*

A. CARDIOVASCULAR
- ☐ Anemia
- ☐ Blood clots/DVT/PE
- ☐ Calf/thigh pain when walking
- ☐ Heart attack
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Stroke
- ☐ Swelling/phlebitis
- ☐ Vein problems

B. RESPIRATORY
- ☐ Asthma
- ☐ Lung disease/emphysema
- ☐ Sleep apnea

C. INFECTIONS
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ STDs

D. METABOLIC
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Liver problems
- ☐ Thyroid problems
- ☐ Weight gain
- ☐ Weight loss

E. GI/GU
- ☐ Bladder infections
- ☐ Dialysis
- ☐ Kidney problems
- ☐ Prostate problems
- ☐ Stomach ulcerations

F. PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric care

G. SUBSTANCE RELATED
- ☐ Alcohol use
  - ☐ Occasional
  - ☐ Daily
  - ☐ History of abuse
- ☐ Drug dependence
- ☐ Tobacco use
  - ☐ Current
  - ☐ Previous

H. OTHER
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Hearing problems
- ☐ Leg ulcerations
- ☐ Seizures
- ☐ Pregnancy

Family history *(Type in or select from list.)*

Additional history *(Type in other relevant information.)*

Legal Name (Last):

4. Please list your previous illnesses/ injuries requiring hospital care, and previous surgeries.

If you can't fit them all here, please bring a list with you.

Illness/injury	Year	Surgery	Year
Illness/injury	Year	Surgery	Year
Illness/injury	Year	Surgery	Year
Illness/injury	Year	Surgery	Year

Height (ft, in) Weight (lbs) Shoe size

5. PLEASE DESCRIBE FOOT PROBLEM

☐ Left ☐ Right ☐ Both

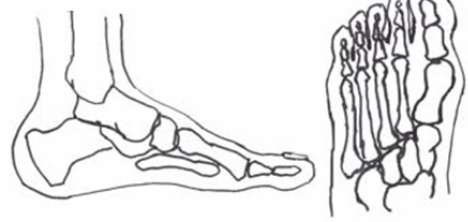
Current foot or ankle problem and duration of problem:

What makes it worse?

What makes it better?

Previous treatment? By whom and where?

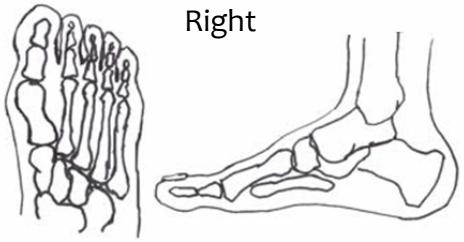
Left



Please use circles or arrows to select painful, injured or problem areas.

(In Adobe Reader, use the Commenting and Markup toolbar. You can also print and circle later.)

Right



People authorized to receive healthcare information:

Name Relation:

Name Relation:

You're all done! Thank you very much.
Now please PRINT using the button below.
You can then FAX it to us, or bring it with you.

Date

Signature _____

Print Form