LAKEWOOD FOOT AND ANKLE SPECIALIST

DR. GLENN AUFSEESER

PODIATRIC PHYSICIAN AND SURGEON OF THE FOOT AND ANKLE

Patient name: _____ Date: _____

Date of birth: _____ Sex: M/F/Other

Address: _____ City: _____ Zip Code: _____

Height: _____ Weight: _____ Primary Doctor: _____

Home Phone: _____ Work: _____ Cell: _____
Can we leave a message at this number? Y/N

In case of emergency, notify: _____ Relationship: _____ Cell: _____
Can we leave a message at this number? Y/N

Pharmacy name: _____ Pharmacy address: _____

Please describe the foot or ankle problem regarding your visit today: _____
_____

Have you ever been to a Podiatrist before? _____
If so, please list reason: _____

Please list any medications you are currently taking: _____
_____
_____
_____

Do you have any allergies to the following?

	YES	NO		YES	NO
Shellfish			Novocain		
Codeine			Aspirin		
Sulfa			Adhesive Tape		
Penicillin			Any other		

Do you smoke? Y/N Do you drink alcohol? Y/N

Does the following run in the family?

Diabetes? Y/N Stroke? Y/N Gout? Y/N

Heart Disease? Y/N Blood Clots? Y/N Cancer? Y/N

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Please check "YES" or "NO" if you have had any of the following?

	YES	NO		YES	NO
Have you had COVID-19 in the past? When? _____			Were you diagnosed in the last 30 days?		
Diabetes			Stomach ulcer		
Abnormal blood pressure			Asthma		
Arthritis			Seizures or epilepsy		
Kidney disease			Difficulty in healing		
Lung Disease			Hepatitis _____		
Heart Problems _____			Cancer _____		
Thyroid Disease			Liver Disease		
AIDS/HIV			Varicose Veins		
Anemia			Angina		
Artificial Heart Valves or Joints			Back Problems		
Bleeding Disorders			Eye Problems		
Chest Pain			Circulatory Problems		
Fainting			Foot or leg cramp		
Gout			Headaches		
Hemophilia			Ear problems		
Radiation Treatment			Shortness of breath		
Sinus Problem			Stroke		
Swelling in feet or ankles			Swollen neck glands		
Tired feet			Weight loss, explained		
Ulcers			Currently nursing		
Currently Pregnant / Months ___			Abnormal bleeding		

I certify that above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date_____

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RELEASE OF MEDICAL INFORMATION/PRIVACY PRACTICE:

In connection with the medical care provided to me at the office of Dr. Glenn Aufseeser, except as otherwise prohibited by law, by my signature below, I hereby grant permission for Dr. Aufseeser office staff and my treating doctor to release medical records information to my health care insurers (including Medicare & Medicaid) my current professional care givers and/or other potential healthcare providers. This information may include any disease or drug/alcohol history.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____ RELATIONSHIP: _____