

Nova Family Podiatry, P.C.

Patient Registration - Medical History

Name _____ Age _____ Date _____
Address _____ City _____
State _____ Zip _____ Home Phone _____
Work Phone _____ Sex: M _____ F _____ D.O.B _____
Social Security # _____

Race: Caucasian _____ African American _____ Asian _____ Latin _____
Language _____

Employer _____ Address _____
Emergency Contact _____ Phone _____
Family Dr. _____ Address _____
Phone _____

How did you hear about our office?

Trend Publication _____ Telephone Book _____ Website _____ Friend _____
Family Member _____ Physician Referral _____ Drive By _____ Other _____

Podiatric History

What is the chief complaint for which you came in to be treated? Include foot, ankle, knee, thigh and hip complaints. _____

Have you ever been to a podiatrist before? Yes _____ No _____
If so, please list the Doctor's name _____ Last Visit _____

Past Medical History

Height _____ Weight _____ Blood Pressure _____

Please check all that apply

| | | |
|-------------------------|----------------------------|----------------------|
| Diabetes _____ | Circulatory Problems _____ | Gout _____ |
| Anemia _____ | Heart Disease _____ | Hepatitis _____ |
| Stomach Ulcers _____ | Heart Failure _____ | Cancer _____ |
| Tuberculosis _____ | Epilepsy _____ | Kind of cancer _____ |
| Lung Problem _____ | Kidney Problem _____ | _____ |
| Bleeding Disorder _____ | High Cholesterol _____ | |
| Asthma _____ | Stroke/Seizures _____ | |
| Arthritis _____ | Depression/Anxiety _____ | |
| Blood Clots _____ | Osteoporosis _____ | |
| Liver Problems _____ | HIV/AIDS _____ | |
| Thyroid _____ | High BP _____ | |

Other medical conditions not listed _____

What if any surgeries have you had? _____

Have you had any previous foot surgery _____

Please list all medications (both prescribed and over the counter, list dosage and frequency) _____

Do you smoke or chew tobacco? Yes _____ No _____

Do you have any allergies to medications? Yes ____ No ____ if yes please list what they are and list the allergy that occurs. _____

Pharmacy Name _____

Pharmacy Phone Number _____

Pharmacy Address _____

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