Nova Family Podiatry, P.C.
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Patient Registration **Today's Date** ____________________

Patient Name: ______________________________ Date of Birth:______________________

SS#: ______________________________ Age:________ Sex: M / F

Address: ____________________City: ________________State: ______ Zip: ___________

Phone #s : Home: ________________Cell: _______________ Work: ________________

Race: (please circle) American Indian, African American (Black), Asian, Caucasian (White) Hispanic, India, Pacific Islander, Undefined, Declined to Specify

Preferred Language: ____________________ Secondary Language ____________________

Marital Status: (please circle) Married, Single, Divorced, Widowed, Separated, Other

Name of Emergency Contact: ________________________ Relationship: ________________

Phone # for Emergencies: Home: _____________________ Cell: _____________________

Family Doctor: (not the practice) _________________________ Phone __________________

Medical History:

What is the chief complaint for your podiatry office or home visit today? _________________

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Were you treated by another podiatrist prior to this visit? Y / N Name: __________________

Height: ____________ Weight: ____________ Blood Pressure: ________________________

Do you have any allergies to medication? ____

Do you have any other allergies? ____

Do you smoke Y / N or chew tobacco Y / N ? How long? _______ Stop Date ____________

Have you had COVID? Y / N Are you vaccinated for COVID? Y / N

First shot date _______________________ Second shot date ___________________

Booster dates: _____________________________

Have you had any surgeries in the past? Please list: ______________________________

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Please circle any conditions that you had in the past or are currently being treated for:

Diabetes	Anemia	Heart Disease/Failure	Asthma	Osteoporosis
Gout	Cancer	High Blood Pressure	COPD	Hepatitis A / B / C
Lupus	HIV/AIDS	Circulatory Problems	Lung Problems	Liver Problems
RA	Stroke	Blood Clots	Covid 19	Kidney Problems
Thyroid	Epilepsy	Bleeding Disorders	Tuberculosis	Stomach Ulcers
Arthritis		High Cholesterol		Depression/ Anxiety

Please list other medical conditions not mentioned above: ______________________________

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Please list any prescription medications that you take as well as any over the counter medications that you use.

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