

MEDICAL INFORMATION—Please fill out as completely as possible

MOUNT KISCO FOOT SPECIALISTS, PLLC

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Name _____ Date of Birth _____

Describe your foot problem _____

How long has it been bothering you? _____

Any past problems with your feet? _____ Any past surgical procedures on your feet? _____

Primary Care Physician _____ Telephone # _____

Address _____

Date of your last exam _____

Which pharmacy do you use? _____ Telephone # _____

GENERAL HEALTH INFORMATION

Current Weight _____ Height _____ Shoe Size _____

Do you exercise regularly? _____ Type of Exercise _____

Most of your day is spent () sitting () standing () walking

Are you allergic or sensitive to:

Antibiotics (penicillin, sulfa, etc.) _____

Allergies to other medications? (please list any) _____

Have you had trouble taking aspirin or NSAIDS (Motrin, Advil, Aleve, etc.) _____

Have you had any trouble with local anesthetics (Lidocaine, Novocaine, etc.) _____

Any sensitivity to : Tape _____ Betadine (iodine) _____ Other _____

Please list medical problems you are currently being treated for _____

Please list medications (prescription and over the counter) you are currently taking _____

Do you have Diabetes? Yes _____ No _____ If yes, do you take insulin? Yes _____ No _____

Have you ever had any surgeries? (please list procedures performed) _____

PLEASE COMPLETE BOTH SIDES

Do you have any artificial joints, heart valve implants or a heart murmur? _____

Have you been told to take antibiotics before having dental work? _____

Do you smoke or use tobacco products? _____ If yes, # packs/day and for how long

Do you have a history of tobacco use, but you have quit? _____ If yes, how long ago?

Do you have a history of alcohol or other substance abuse? _____

How many alcoholic beverages do you consume in a typical week? _____

Check if you have or have a history of symptoms related to the following:

- Eyes, Ears, Nose, Throat (problems with vision, hearing, sinus etc.)
- Dermatological disorders (skin cancer, rashes, fungal infections, etc.)
- Cardiovascular disorders (high blood pressure, poor circulation, irregular heartbeat etc.)
- Endocrine disorders (diabetes, hypothyroidism, etc.)
- Gastrointestinal disorders (acid reflux, stomach ulcer, irritable bowel etc.)
- Genitourinary disorders (kidney stones bladder problems etc.)
- Neurological disorders (dizziness, seizures, tremors, numbness etc.)
- Musculoskeletal disorders (joint pain, arthritis, osteoporosis, etc.)
- Respiratory disorders (shortness of breath, asthma, emphysema etc.)
- Hematological disorders (bleeding/clotting problems, high cholesterol etc.)
- Psychiatric disorders (panic attacks, depression, anxiety, etc.)
- Infections (Lyme disease, Hepatitis, HIV, sexually transmitted disease)
- Constitutional (fever, chills, malaise, unexplained weight loss, etc.)

Please list any other symptoms you are having

FAMILY HISTORY

Is there a family (blood relative) history of (please list relationship)

- | | |
|--|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Foot Problems _____ | <input type="checkbox"/> Bleeding Disorders _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Neurological Problems _____ | <input type="checkbox"/> Other _____ |

Signature _____ Date _____