



**Patient Update Form  
PODIATRY AFFILIATES, PC**

Today's Date \_\_\_\_\_ Office \_\_\_\_\_ Doctor \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Dr.	<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss.	<input type="checkbox"/> Sr. <input type="checkbox"/> Jr.
Street Address			City	State	Zip Code	
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	E-Mail Address			

<b>DOB:</b>	Pharmacy Name	Pharmacy Address	Pharmacy Phone #
Primary Medical Doctor	Date of last visit	Doctors Street Address	Doctor Phone#

**MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING:  
PRESCRIPTION AND OVER-THE-COUNTER)**  
*Use Other Side Of Page If Necessary*

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

<b><u>ALLERGIES</u></b>			
1.		3.	
2.		4.	

**Chief Complaint:**

**How long have you had this problem: \_\_\_\_\_ Months/Years**

SHOE SIZE	HEIGHT	WEIGHT
DO YOU DRINK?	<input type="checkbox"/> NO <input type="checkbox"/> YES	DRINKS PER WEEK
DO YOU SMOKE?	<input type="checkbox"/> NO <input type="checkbox"/> YES	PACK(S) PER DAY

**Indicate which of the following you had or have at present. Check Yes or No to each item**

Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Communicable Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Motion Sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart (Surgery, Disease, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse/Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems / Reflux / Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there a chance you may be pregnant?  Yes  No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the office of any change in my health or medication.

X	
<b>Patient/Guardian Signature</b>	<b>Date</b>
HISTORY REVIEWED BY: DR. SIGNATURE	DATE