JOSEF J. GELDWERT, D.P.M.

PATIENT INFORMATION FORM

Date:

Patient Name: Date of Birth:

Sex: ◯ Male ◯ Female

Gender Identity: ◯ Male ◯ Female ◯ Other

May we leave a message?

Home Phone: ◯ Yes ◯ NO

Cell Phone: ◯ Yes ◯ NO

Work Phone: ◯ Yes ◯ NO

E-Mail:

Primary Language: Race: Ethnicity:

Emergency Contact: Relationship: Phone:

Primary Care Doctor: Phone:

Pharmacy: Phone:

Location:

Is there a family member or other person you would like for us to share your medical information?

◯ Yes Name(s):

◯ No

Who is responsible for payment? Relationship:

Address: City/State: Zip:

Phone: Who referred you to our office:

INSURANCE INFORMATION

Primary Insurance Name: Phone #:

ID# Group#:

Address: City/State: Zip:

Phone:

Insured Name: Date of Birth: Employer:

Secondary Insurance Name: Phone #:

ID# Group#:

Address: City/State: Zip:

Phone:

Insured Name: Date of Birth: Employer:

Please List Medications You Are Currently Taking (Including Over-The-Counter, Vitamins, Herbal Supplements)

Patient Name:

Name:

Dosage:

Frequency:

Please List All Prior Surgeries:

Date: Type of Surgery:

Date: Type of Surgery:

Date: Type of Surgery:

Please List All Hospitalization (Other than for Surgery)

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Current Use of Alcohol: ☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily ☐ History of Abuse

Use of Tobacco: ☐ Never ☐ Quit How Long Ago?

Smoke: Pack/Day For Years

Recreational Drug Usage: ☐ Never ☐ Quit How Long?

Type:

Current Use: Type ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 100%

EXERCISE:
☐ NEVER ☐ RARE
☐ OCCASSIONAL ☐ WEEKLY
☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HOSTORY

DO YOU HAVE A FAMILY HISTORY OF:
☐ DIABETES TYPE 1 ☐ DIABETES TYPE 2
☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE
☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTRITIS

OTHER: _____

PATIENT NAME: _____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS: LIST:
☐ ANESTHESIA ☐ FOODS
☐ TAPE ☐ LATEX
☐ SHELLFISH ☐ IODINE
☐ NONE KNOWN

Other: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Acid Reflux	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N
Anemia	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N
Asthma	☐ Y	☐ N	Liver Disease	☐ Y	☐ N
Back Trouble	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N
Bladder Infections	☐ Y	☐ N	Migraine Headaches	☐ Y	☐ N
Abnormal Bleeding	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N
Blood Clots	☐ Y	☐ N	Neuropathy	☐ Y	☐ N
Blood Transfusion	☐ Y	☐ N	Open Sores	☐ Y	☐ N

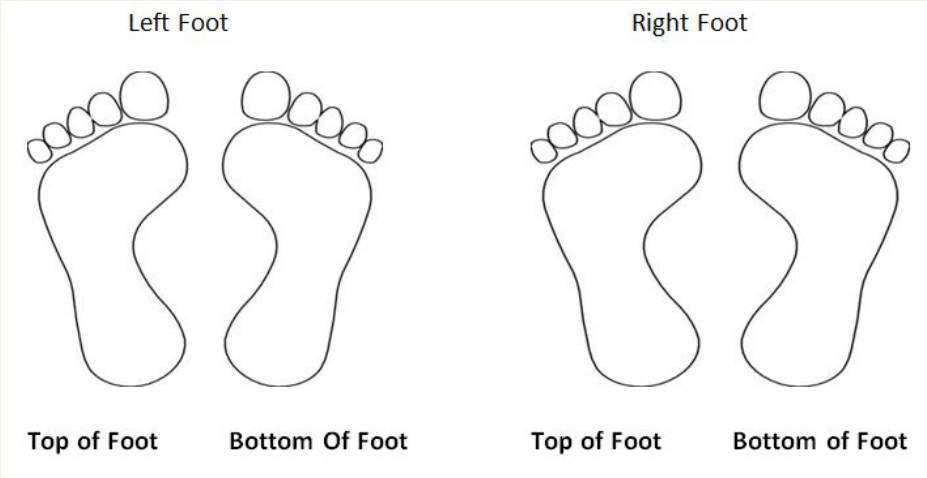
Bronchitis/Emphysema	☐ Y	☐ N	Pneumonia	☐ Y	☐ N
Cancer	☐ Y	☐ N	Polio	☐ Y	☐ N
COVID-19	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Diabetes (I or II)	☐ Y	☐ N	Sickle Cell Disease	☐ Y	☐ N
Fibromyalgia	☐ Y	☐ N	Skin Disorder	☐ Y	☐ N
Gout	☐ Y	☐ N	Sleep Apnea	☐ Y	☐ N
Heart Attack	☐ Y	☐ N	Stomach Ulcers	☐ Y	☐ N
Hear Disease	☐ Y	☐ N	Stroke	☐ Y	☐ N
Hepatitis	☐ Y	☐ N	Thyroid Disease	☐ Y	☐ N
HIV+/AIDS	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N

OHER CONDITIONS: _____

CURRENT PROBLEM

What Specific Problem Brings You to Our Office Today? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



Patient Name: _____

How long ago did this problem first start? _____

Did your pain or problem: ☐ Begin All Of A Sudden ☐ Gradually Develop

How would you describe your pain

☐ No Pain	☐ Sharp Pain	☐ Dull	☐ Aching
☐ Burning	☐ Radiating	☐ Itching	☐ Stabbing

Other

How would you rate your pain on a scale from 0 to 10?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ 7 ☐ 8 ☐ 9 ☐ 10

Since the time your pain or problem began, has it:

☐ Stayed the Same ☐ Become Worse ☐ Improved

What makes your pain or problem feel worse?

☐ Walking ☐ Standing ☐ Daily Activities
☐ Resting ☐ Dress Shoes ☐ High Heels
☐ Flat Shoes ☐ Any Closed Toe Shoe ☐ Running

Other

What makes your pain or problems feel better?

What treatments have you had for this problem?

How has this problem affected your lifestyle or ability to work?

Was the problem caused by an injury? ☐ Yes ☐ No Describe

If yes, was it a work related injury? ☐ Yes ☐ No

☐ I acknowledge that I have received or read the HIPPA/Patient Privacy document

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print Name of Patient, Parent or Guardian

If Other Than Patient, Relationship to Patient

Signature Date