Active Podiatry
Yong S. Chae, DPM
www.activepodiatry.com

Please Print Date _____

Patient's Name _____
Last First MI
Home Phone_____ Mobile Phone _____ Email _____
Address _____ City _____ State _____ ZIP _____
Birth Date _____☐Male ☐ Female Social Sec. # _____ Marital Status _____
Patient's Employer _____ Employer Phone _____

If minor, responsible party name _____ Relationship _____
Birth Date _____ ☐ Male ☐ Female Social Sec. # _____ Marital Status _____
Address _____ City _____ State _____ ZIP _____
Resp. Party Employer _____ Employer Phone _____

In case of emergency, please contact:
Name _____ Relationship _____ Phone _____
Address _____

MEDICAL INSURANCE INFORMATION
☐ Check if Not Insured
Primary Insurance Co. _____ Name of Insured _____
Insured's Social Sec. # _____ Insured's Date of Birth _____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Insurance Co. _____

CURRENT COMPLAINT
Reason for seeing doctor today _____
Duration of current condition _____Have you had any treatments for your current condition? ☐ Yes ☐ No
If yes, explain _____
Have you seen a podiatrist before? ☐ Yes ☐ No
If yes, Doctor's name _____ Date last seen _____

MEDICAL HISTORY
Have you ever had or been treated for the following?

☐ AIDS/HIV	☐ Arthritis	☐ Asthma	☐Bleeding Disorders
☐ Blood Clots/DVT	☐ Cancer	☐ Diabetes	☐ Fibromyalgia
☐ Gout	☐ Heart problems	☐ Hepatitis/Liver	☐ High Blood Pressure
☐ High Cholesterol	☐ Kidney Problems	☐ Melanoma	☐ Neuropathy
☐ Osteoporosis	☐ Poor Circulation	☐ Psychiatric Disorders	☐ Psoriasis
☐ Seizures	☐ Heart Burn	☐ Tuberculosis	☐ Varicose Veins
☐ Heart Attack	☐ Emphysema	☐ COPD	☐ Thyroid Disorders
☐ Stroke	☐ Other	☐ Other	☐ Other

MEDICAL HISTORY (Continued)

Please list any surgeries you have had: Date of Surgery:

_____
_____
_____
_____

SOCIAL HISTORY

Height _____ Weight _____ lbs Shoe Size _____ Age _____ Dominant Hand _____
Do You Smoke? ☐ No ☐ Yes Pack/day _____ Former Smoker? ☐ No ☐ Yes
Alcohol Use: ☐ None ☐ Occasional ☐ Mild/Moderate ☐ Heavy
Exercise: ☐ None ☐ Occasional ☐ Regular Light ☐ Regular Moderate ☐ Regular Heavy
Occupation: _____☐ N/A ☐Sedentary ☐ Mild/Moderate Activity ☐ Very Active

CURRENT MEDICATIONS

Medication	Dosage	Frequency

Do you have any allergies? ☐ No ☐ Yes (please specify below)
☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics / Novocain ☐ Latex ☐ Sulfa drugs ☐ Adhesive tape
☐ Vicodin ☐ Demerol ☐ Aspirin ☐ Iodine / Betadine ☐ Other _____

Any Other Pertinent Medical / Familial History or Information?
_____
Primary Care Physician _____ Date Last Seen _____
Address _____ City _____ ZIP _____
Preferred Pharmacy_____ Address _____

REFERRED BY:

☐ Doctor _____Address _____ City _____ ZIP _____
☐ Patient or Friend (please list) _____
☐ Insurance
☐ Internet (please specify) ☐Our Website ☐Google ☐ Yahoo ☐ Bing ☐ Other
☐ Other (please list) _____

I certify that the above information is true and correct to the best of my knowledge.

Signature _____ Date _____