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Today's Date: / /

PATIENT INFORMATION FORM

Name			Preferred Name	
Legal Sex ☐ F ☐ M	Birth Date / /		Social Security # - -	
Address			City	State
Zip Code -	Email			
Home Phone ( ) -	Cell Phone ( ) -		Work Phone ( ) -	
Would you like to receive text messages for appointment reminders? ☐ Yes ☐ No				
What is your preferred contact method from our office? ☐ Home ☐ Cell ☐ Work ☐ Patient Portal				
Primary Language Spoken ☐ English ☐ Other:			Race/Ethnicity	
Marital Status ☐ S ☐ M ☐ D ☐ W ☐ DP				
Primary Care Physician	Phone ( ) -		Last Seen / /	
Pharmacy Name	Pharmacy Location			
Employer	Occupation			
Who is in charge of your medical management? ☐ Self ☐ Other:				
Emergency Contact Name	Relationship		Phone ( ) -	

INSURANCE INFORMATION

Primary Insurance:	☐ Aetna	☐ BCBS	☐ Cigna	☐ Humana	☐ Medicare	☐ Other:
Secondary:	☐ Aetna	☐ BCBS	☐ Cigna	☐ Humana	☐ Medicare	☐ Other:
Member's Name:				Member's Date of Birth: / /		
If the patient is a minor (17 and under), name of guarantor or responsible party:						

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

Internet Search: ☐ Google using key words ______________________ ☐ Website ☐ Facebook / Social Media

Referral: ☐ Friend/Patient Name _________________________ ☐ Doctor ______________________________

Local Ad: ☐ Val Pak ☐ Lemont Life ☐ Lovin' Lemont Livin'

Phone Book: ☐ Home Pages

Church Ad: ☐ St. Al's ☐ St. Cyril's ☐ St. Pat's ☐ Previous Patient

Other: ☐ Walk-in / Saw Sign ☐ Insurance Site ☐ Other _______________________________

Allergies

- ☐ No known allergies
- ☐ No known drug allergies

I am able to take NSAIDs (Advil, Aleve, Aspirin, ibuprofen)

☐ Yes ☐ No: ______________

Allergy / Intolerance	Reaction	Severity
		mild mod severe
		mild mod severe
		mild mod severe
		mild mod severe

Medications

Please list all medications and supplements you are taking, or you may provide a complete separate list.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Past Medical & Surgical History

Condition	***Diagnosis Year***	***Condition***	***Diagnosis Year***	***Condition***	***Diagnosis Year***
☐ AIDS / HIV		☐ Frostbite		☐ Peripheral Neuropathy	
☐ Anemia		☐ GERD / Acid Reflux		☐ Peripheral Vascular Disease	
☐ Anxiety / Depression		☐ Gout		☐ Polio	
☐ Arthritis		☐ Headache/Migraine		☐ Pulmonary Embolism	
☐ Asthma		☐ Heart Disease		☐ Raynaud's Disease	
☐ Back Pain / Sciatica		☐ Hepatitis A / B / C		☐ Rheumatoid Arthritis	
☐ Bleeding Disorder		☐ Hernia		☐ Seizures / Epilepsy	
☐ Blood Clots / DVT		☐ Hypertension (Blood Pressure)		☐ Stroke / CVA	
☐ Cancer		☐ Kidney Disease		☐ Substance Abuse	
☐ Diabetes - Type 1 / 2		☐ Leg / Foot Ulcers		☐ Thyroid Problems	
☐ Dialysis		☐ Liver Disease		☐ Tuberculosis	
☐ Dyslipidemia (High Cholesterol)		☐ Lung Disease		☐ Varicose Veins	
☐ Environmental allergies		☐ Organ Transplant		☐ Other:	
☐ Fibromyalgia		☐ Osteoporosis		☐ Other:	
☐ Foot Deformity		☐ Pacemaker / Defibrillator		☐ Other:	

Surgery	***Year***	***Surgery***	***Year***	***Other Surgery***	***Year***
☐ Anesthesia problems		☐ Leg stent / bypass R / L		☐ Cataracts	
☐ Heart bypass / stent		☐ Vein Procedure		☐	
☐ Hip Replacement R / L		☐ Foot/Ankle		☐	
☐ Knee replacement R / L		☐ Foot/Ankle		☐	

Other Medical History

Height: ______ ' ______ "   Weight: __________ lbs   Shoe size: *Right* __________ *Left* __________

Major medical conditions in your family:

- ☐ Unknown
- ☐ Mother: ______________________________
- ☐ Father: ______________________________
- ☐ Sibling: ______________________________
- ☐ Other: ______________________________

Cigarette Smoking Use:	☐ Never	☐ Former smoker for _______ yrs	☐ Current smoker: _______ yrs _______ PPD
Chewing Tobacco Use:	☐ Never	☐ Former user for _______ yrs	☐ Current user: _______ yrs Type:
Vaping/E-cigarette Use:	☐ Never	☐ Former user for _______ yrs	☐ Current user: _______ yrs

Alcohol intake:	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
Illicit drug use:	☐ None	☐ ______________		☐ Medical marijuana
Special diet:	☐ No	☐ Yes : ______________		

Activity level at work:	☐ Sitting	☐ Standing	☐ Walking	☐ Driving
Exercise level:	☐ Minimal	☐ Occasional	☐ Moderate	☐ Heavy

Sporting activities: ______________________________

Difficulty walking or climbing stairs?	☐ No	☐ Yes
Are you able to care for yourself?	☐ No	☐ Yes
Legally blind in one or both eyes?	☐ No	☐ Yes

Reason For My Visit Today

Please list up to 2 conditions, with #1 being the most important.

1) **Reason for my visit:** ______________________ **Location:** ______________

How long have you had this: __________ days wks mos yrs   **Severity**: mild moderate severe. Pain levels: + / 10

Symptoms: ______________________________

What makes it feel worse? ______________________________

How often is this bothering you? ______________ **Possible cause:** ______________

Any past treatments: ______________________________

Any treatment goals: ______________________________

2) **Reason for my visit:** ______________________ **Location:** ______________

How long have you had this: __________ days wks mos yrs   **Severity**: mild moderate severe. Pain levels: + / 10

Symptoms: ______________________________

What makes it feel worse? ______________________________

How often is this bothering you? ______________ **Possible cause:** ______________

Any past treatments: ______________________________

Any treatment goals: ______________________________