Michelle Castiello, DPM
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600 Mamaroneck Ave, Suite 102, Harrison, NY 10528
T: 914-723-8100

PODIATRIC HISTORY

Patient Name: _____ **Date of Birth:** _____

Referring Physician: _____
Name and address

Please list the chief complaint for which you came to be treated (include foot, ankle, knee, thigh and hip complaints)

_____

_____

_____

Have you ever been under the care of a podiatrist? Yes_____ No_____

If yes, please list: Dr. Name:_____ Date of last visit: _____

Is there any personal or family history of diabetes? _____

Your occupation(s): _____

Cigarette/ Tobacco use:_____ Years Smoked: _____

Athletic activities in which you participate: (please indicate frequency)

_____

_____

Please indicate which foot problems you have had in the past:

Ankle pain:	Yes ☐ No ☐	Foot or leg cramps:	Yes ☐ No ☐
Athletes foot:	Yes ☐ No ☐	Heel pain:	Yes ☐ No ☐
Bunions:	Yes ☐ No ☐	Ingrown toenails:	Yes ☐ No ☐
Corns & Calluses:	Yes ☐ No ☐	Plantar warts:	Yes ☐ No ☐
Cramps/ Numbness in feet or legs:	Yes ☐ No ☐	Tired feet:	Yes ☐ No ☐
Flat Feet:	Yes ☐ No ☐	Swelling in ankles or feet:	Yes ☐ No ☐

Other concerns: _____

_____

_____

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MEDICAL HISTORY

Patient Name:_____ **Date of Birth:**_____

MEDICATIONS

Include over the counter medications and vitamins: _____

_____

_____

Pharmacy Name:_____ Phone: _____

Do you take oral contraceptive? Yes ☐ No ☐

ALLERGIES

Please check all known allergies:

Adhesive tape:	Yes ☐ No ☐	Penicillin:	Yes ☐ No ☐
Anticoagulant therapy:	Yes ☐ No ☐	Seafood:	Yes ☐ No ☐
Aspirin:	Yes ☐ No ☐	Sulfur:	Yes ☐ No ☐
Codeine:	Yes ☐ No ☐	Other:_____	
Demerol:	Yes ☐ No ☐		
Iodine:	Yes ☐ No ☐	Other:_____	
Latex:	Yes ☐ No ☐	Other: _____	
Local Anesthetics:	Yes ☐ No ☐		
Novocain:	Yes ☐ No ☐		

GENERAL

Past Surgeries: _____

_____

_____

Hospitalizations other than for surgeries listed above: _____

_____

_____

Family physician:_____ Last visit: _____

Are you now, or have been, under any doctor's care for any reason over the past two years? Yes ☐ No ☐
If yes, please explain: _____

_____

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Patient Name:_____ **Date of Birth:** _____

GENERAL (cont.)

Please check YES or NO to indicate if you have had a history of the following:

	YES	NO		YES	NO
AIDS/ HIV			Hepatitis or jaundice		
Allergies to anesthetics			High blood pressure		
Allergies to medications/ drugs			Kidney problems		
Anemia			Liver disease		
Angina			Low blood pressure		
Arthritis			Neuropathy		
Artificial heart valves or joints			Phlebitis		
Asthma			Psychiatric care		
Back problems			Radiation treatment		
Bleeding disorders			Rash		
Cancer			Respiratory disease		
Chemical dependency			Rheumatic fever		
Chest pain			Shortness of breath		
Chronic diarrhea			Sinus problems		
Circulatory problems			Special diet		
Diabetes			Stroke		
Ear problems			Swelling in ankles and feet		
Epilepsy			Swollen neck glands		
Eye problems			Tired feet		
Fainting			Tuberculosis		
Foot or leg cramps			Ulcers		
Gout			Varicose veins		
Headaches			Venereal disease		
Heart disease			Weight loss, unexplained		
Hemophilia					

TREATMENT CONSENT

I hereby consent and give permission to the doctor and their designated assistants to administer and perform such procedures upon me as the Doctor deems necessary and that have been fully discussed with me beforehand.

_____

Signature of patient, parent, guardian or personal representative *Date*

_____

Print Name of patient, parent, guardian or personal representative *Date*