



PEABODY PODIATRY

Podiatrists - Foot Surgeons
6 ESSEX CENTER DRIVE, SUITE 208
PEABODY, MA 01960

www.peabodypodiatrist.com

TEL. 978-531-9969 • FAX 978-531-3745

Emergency contact

Name: _____

Number: _____

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

PHONE # _____

WORK # _____

CELL # _____

BIRTH DATE _____

INSURANCE NAME _____

SUBSCRIBER _____

SOCIAL SECURITY # _____

DATE OF LAST PHYSICAL _____

****PRIMARY CARE PHYSICIAN AND ADDRESS** _____

****PHARMACY NAME AND LOCATION** _____

HOW WERE YOU REFERRED TO THIS OFFICE? _____

PLEASE **CIRCLE** IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

DIABETES

AIDS

ANEMIA

ANXIETY

ARTHRITIS

ASTHMA

BLOOD CLOTS

CANCER

DEPRESSION

VARICOSE VEINS

GOUT

HEART DISEASE

HEART MURMUR

HIGH BLOOD PRESSURE

HIGH CHOLESTEROL

HIV POSITIVE

KIDNEY DISEASE

LUNG DISEASE

NEUROPATHY

VENEREAL DISEASE

PHLEBITIS

POOR CIRCULATION

RHEUMATIC FEVER

SCARLET FEVER

SEIZURES

SKIN CANCER

STROKE

THYROID DISORDER

TUBERCULOSIS

ULCERS

OTHER _____

“I request that payment of authorized Medicare or any other insurance benefits to be made on my behalf to Dr. Paul S. Peicott or Dr. Nancy V. Prechtel for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration, or its agents, any information needed to determine benefits for related services.”

HMO PATIENTS: I am aware that I will be responsible for payment of services if I did not obtain a referral for today's visit.

SIGNATURE _____ DATE _____

DATE: _____ NAME: _____ AGE: _____

Please list the **names and doses** of **ALL** medications/vitamins/supplements you are currently taking:

Please list **allergies** you have to ANY medications, food, metal, latex, adhesive tape, etc:

Type of reaction _____

Type of reaction _____

Type of reaction _____

SOCIAL HISTORY

Do you smoke? _____ # packs per day _____ If you quit, how long ago? _____
Do you drink alcohol? _____ If yes, how often? _____ If you quit, how long ago? _____
Do you use illicit drugs? _____ If yes, what and how often? _____ If you quit, how long ago? _____
Do you have a walking/exercise routine? _____ How many times per week? _____
What is your occupation? _____

FAMILY HISTORY

Does/did anyone in your family have any of the following? If YES who?
Diabetes _____ Heart disease _____
Cancer (type) _____ Stroke/Blood clot _____

SURGICAL HISTORY

Please list ALL past **surgical procedures**: _____

REVIEW OF SYSTEMS: CIRCLE if you have you ever experienced problems with any of the following?

- | | | | |
|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------|
| <u>HEENT</u>
Headaches
Vision problems
Dizziness
Ringing in ears
Nose bleeds
Difficulty swallowing | <u>RESPIRATORY</u>
Shortness of breath
Pneumonia | <u>HEMATOLOGIC/LYMPH</u>
Blood disorder
Lymph node disorder | <u>NEUROLOGICAL</u>
Neuromuscular problems
Neuropathy |
| <u>CARDIOVASCULAR</u>
Chest pain
Congestive heart failure | <u>GASTROINTESTINAL</u>
Acid Reflux
Stomach ulcers | <u>MUSKULOSKELETAL</u>
Joint pain
Muscle pain
Back pain/injury | <u>INTEGUMENTARY</u>
Melanoma
Eczema
Psoriasis |
| <u>GENITOURINARY</u>
Bladder problems
Kidney problems | <u>ALLERGIC/IMMUNOLOGIC</u>
Seasonal allergies
Autoimmune disorder | | |

*****What problem are you having with your foot today that brings you to the office? _____**
