Existing Patient Update Form **Henderson Podiatry** **Today's Date: _____**

Name: _____ Date of Birth: _____
Sex: __Male __Female **Marital Status:** __Single __Married __Widowed __Divorced **SS#:_____**
Email: _____ Spouse/Partner Name: _____
Address: _____
Home #: _____ Cell #: _____ Other #: _____
Emergency Contact Name: _____ Phone #: _____
Primary Care Physician: _____ Phone #: _____
Address: _____ Date Last Seen: _____

Medical History:	Cancer	Diabetes	High Blood Pressure	Polio
AIDS/HIV	Cardiac Disease	Edema	Irritable Bowel Syndrome	PVD
Alcoholism	Chronic Heart Disease	Emphysema	Kidney Problems	Stroke
Arteriosclerosis	Claudication	Fibromyalgia	Lymphedema	Thrombophlebitis
Asthma	Congestive Heart Failure	GERD	Osteoporosis	Thyroid Disorder
Bronchitis	Crohn's Disease	Gout	Pacemaker	Ulcers
		Hepatitis	Phlebitis	Varicose Veins
			Pneumonia	None

Are you pregnant? Yes No **Are you nursing?** Yes No **Do you smoke?** Yes No **If yes, how many packs per day?** ___
Do you drink alcohol? Yes No **Do you exercise regularly?** Yes No **Advance Care Plan, Living Will? Yes No**

Pneumococcal Vaccine? Yes No

Surgical History: No known surgical procedures
Have you ever had any surgical procedures? Yes No
If yes, please describe: _____
Do you have any artificial joints? Yes (where? _____) No **Do you have an artificial heart valve?** Yes No

Family History: Is there any family history (blood relative)
Blood Clot: _____ Heart Disease: _____
Circulation Problems: _____ High Blood Pressure: _____
Diabetes/Type: _____ Neurological: _____
Other: _____ Strokes: _____

Current Medications

__No known medications __I take the following medications
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____
Name: _____

Use the back of this form if more room is needed

Allergies

__No known allergies __No known drug allergies
Name: _____
Name: _____
Name: _____
Name: _____

Vital Signs

Blood Pressure: _____ / _____
Height: _____ Weight: _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any updates to the information listed above. (*Assignment of Benefits*): I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPAA Privacy*): I acknowledge that I have received my HIPAA Privacy Practices Notice. (*Medication History*): I authorize the doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____