DR. REGIS BOUDREAU, D.P.M, LLC Date ___ / ___ / ____

WELCOME TO OUR OFFICE!

(Confidential information – important for our files and your health)

Last Name: ______________________________________ First Name/MI: _______________________________

Street: _______________________________________ City: ____________________ State: ______ Zip: ________

Home Phone:_____________________________________ Cell Phone: __________________________________

Sex: M F Date of Birth: ______ / ______ / ______ Age: ________

Who should be contacted in case of emergency (name and phone)? _______________________________________

____

Who is responsible for this account (name, address, and phone)? _______________________________________

____

Workman's comp/auto related claim? Yes No Date of injury: ______ / ______ / ______

Claim # and contact person: ____

Medical Insurance and Policy #'s: ____

Subscriber name and DOB (if other than patient): ____

Patient Employer: _______________________ Occupation: _____________ Business Phone: ________________

By what name do you wish to be addressed? ____

Who may we thank for referring you to our office? ____

MEDICAL HISTORY

Foot complaint: ____

Have you ever seen another podiatrist? Yes No For what reason? ______________________________

Primary Care Physician: ____________________________________ Office Phone:_________________________

Date last seen by PCP: ________________________Weight now ______________1 year ago _______________

(Please turn over)

Do you or have you had any of the following?

( ) Diabetes
( ) Heart Attach
( ) Heart Problems
( ) Poor Circulation
( ) Stomach Ulcers
( ) Kidney Disease
( ) Skin Cancer or Melanoma
( ) Hypertension
( ) Gout
( ) Asthma
( ) Anemia
( ) Heart Murmer
( ) Liver Trouble
( ) Blood Clots
( ) Leg Cramps
( ) Thyroid Trouble
( ) Hepatitis
( ) Recent weight loss
( ) Artificial Heart Valves/Joints
( ) Cancer
( ) Seizures
( ) Glaucoma
( ) Arthritis ( ) RA ( ) OA
( ) Pacemaker
( ) Tuberculosis
( ) AIDS
( ) Low Back Pain

Please list past operations or serious injuries: ______________________________

____

Please list all current medications: ______________________________

____

Are you allergic or sensitive to:

( ) Penicillin
( ) Codeine
( ) Iodine
( ) Keflex
( ) Drugs
( ) Adhesives
( ) Seafood
( ) Novocaine
( ) Anesthetics
( ) Other: ______________________________

Any family history of:

( ) Foot Problems ______________________________

( ) Diabetes
( ) High Blood Pressure
( ) Heart Disease
( ) Arthritis
( ) Skin Cancer or Melanoma

Social History:

Do you smoke cigarettes? ( ) Yes ( ) No PPDx ___________ years

Recreational drugs? ____________________

Do you drink alcohol? How much? ______________________________

FOR WOMEN ONLY: Are you pregnant? ( ) Yes ( ) No How many months? ________

Patient Signature: ____ Date: ____________