Ivan J. Nosacek, D.P.M.

PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____ (First) _____ (Middle Initial) _____ (Last)

Birthdate: _____ Male Female

Address: _____ (Street)

_____ (Street (Additional))

_____ (City) _____ (State) _____ (Zip Code)

Home Number: ( ) _____

Work Number: ( ) _____

Preferred #: ( ) _____

Home Work Cell

Marital Status: S M D W

Email Address: _____

Employer: _____

Employment Status: Student PT FT Retired

Social Security Number: _____

(used only as an identifier within our practice)

Referred by: _____

Physician Family/Friend Advertisement

Primary Care Doctor: _____

Date Last Seen: _____

PRIMARY INSURANCE: _____ (Insurance Company Name)

Referral Needed? YES NO

ID Number: _____ Group Number: _____

Effective Date: _____

Policy Holder's Name: _____

SELF SPOUSE PARENT

If other than SELF: Address: _____

Telephone: _____

_____

DOB: _____

Employer: _____

SSN: _____

SECONDARY INSURANCE: _____

Referral Needed? YES NO

ID Number: _____ Group Number: _____

Effective Date: _____

Policy Holder's Name: _____

SELF SPOUSE PARENT

If other than SELF: Address: _____

Telephone: _____

_____

DOB: _____

Employer: _____

SSN: _____

Reviewed Today:_____/_____/_____ Ivan J. Nosacek, D.P.M._____

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

Social History:

Do you smoke? Please check one box below

☐ Never Smoked
☐ Former Smoker/Quit
How many years did you smoke? _____ How many years ago did you quit? _____
☐ Smoke Everyday
☐ Smoke Sometimes (Average pack per day?_____)
How much do you smoke per day? _____

How many alcoholic drinks per day? _____
Do you use any illicit drugs, if yes please list ? _____
Do you use chewing tobacco? ☐Never ☐Sometimes ☐Daily ☐Quit (If so, when?_____)

Family Medical History (please mark the age at which someone in your family was diagnosed or died)

History of:	**Family Member:**
Heart Disease:	_____
Thyroid:	_____
High Cholestrol:	_____
Lung Disease:	_____
Alzheimers Disease:	_____
Glaucoma:	_____
Depression:	_____

Do you have a Legal Guardian or health care Power of Attorney? ☐ Yes ☐ No
If yes, Name:_____ Relationship: _____Phone #:_____

Emergency Contact:_____ Relationship: _____ Phone #:_____

Emergency Contact:_____ Relationship: _____ Phone #:_____

Pharmacy:_____ Location: _____ Phone #:_____

May we leave you a message on answering machine/voicemail:☐Yes ☐No
If yes, may we leave sensitive information such as medications or past due bill? ☐Yes ☐No

May we email you?☐Yes ☐No If yes, please confirm email _____
If yes, may we communicate sensitive information such as medications or past due bill? ☐Yes ☐No

Reviewed Today:____/____/____ Ivan J. Nosacek, D.P.M._____

PODIATRY MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth:____/____/____
First MI Last

Age_____ Male Female Current Primary Physician:_____ Date Last Seen:____/____/____

Occupation:_____ Previously seen podiatrist(s):_____

REASON FOR YOUR VISIT:_____

HISTORY:

How long has the problem been present?_____

Can you think of any incident which could have triggered the problem?_____

Is the problem the result of an injury? NO YES (explain)_____

If so, what date did it happen? ____/____/____ Did the injury happen at work? NO YES (additional form is required if YES)

What have you done to relieve the foot/ankle problem?_____

REVIEW OF SYSTEMS (FOOT / ANKLE):

Problem	Current	Past		
Ankle Pain	_____	_____	Right	Left
Arch Pain	_____	_____	Right	Left
Athlete's Foot	_____	_____	Right	Left
Bunion	_____	_____	Right	Left
Corn	_____	_____	Right	Left
Callus	_____	_____	Right	Left
Cramps, Foot	_____	_____	Right	Left
Cramps, Leg	_____	_____	Right	Left
Flatfoot	_____	_____	Right	Left
Foot pain	_____	_____	Right	Left
Fungus nails	_____	_____	Right	Left
Heel Pain	_____	_____	Right	Left
Infection, foot	_____	_____	Right	Left
Infection, ankle	_____	_____	Right	Left
Intoeing	_____	_____	Right	Left
Numbness, foot	_____	_____	Right	Left
Sweating, excess	_____	_____	Right	Left
Swelling-ankle/ft	_____	_____	Right	Left
Toe pain	_____	_____	Right	Left
Wart(s)	_____	_____	Right	Left

ALLERGIES:

Adhesive Tape	YES	NO
Aspirin	YES	NO
Codeine	YES	NO
Eggs	YES	NO
Iodine	YES	NO
Local Anesthetics	YES	NO
Novacain	YES	NO
Penicillin	YES	NO
Rubber	YES	NO
Shellfish	YES	NO

Other: _____

Other: _____

MEDICATIONS YOU TAKE (or attach list):

(1) _____
(2) _____
(3) _____
(4) _____

(Continued on next page)

PLEASE PRINT YOUR FULL NAME:_____ Date of Birth____/____/____

Reviewed Today:_____/_____/_____ Ivan J. Nosacek, D.P.M._____

REVIEW OF SYSTEMS / PAST HISTORY (GENERAL MEDICAL):

Problem	Personal	Family
AIDS/HIV	_____	_____
Anemia	_____	_____
Arthritis, osteoarthritis	_____	_____
Arthritis, rheumatoid	_____	_____
Asthma	_____	_____
Back problems	_____	_____
Bleeding/blood disorders	_____	_____
Cancer, cancer treatment	_____	_____
Chemical dependency	_____	_____
Chest pain	_____	_____
Circulation problems	_____	_____
Diabetes	_____	_____
Diarrhea, chronic	_____	_____
Ear/hearing problems	_____	_____
Eye problems	_____	_____
Fainting	_____	_____
Gout	_____	_____
Headaches, chronic	_____	_____
Hemophilia	_____	_____
Hepatitis	_____	_____
Other health problem(s):	_____	

_____

Problem	Personal	Family
High blood pressure	_____	_____
Kidney problems	_____	_____
Liver disease	_____	_____
Low blood pressure	_____	_____
Nervous problems	_____	_____
Phlebitis	_____	_____
Psychiatric disorder(s)	_____	_____
Rash, chronic	_____	_____
Respiratory disease	_____	_____
Rheumatic fever	_____	_____
Shortness of breath	_____	_____
Sinus problems	_____	_____
Stroke	_____	_____
Swelling, chronic-ankle	_____	_____
Swelling, chronic-foot	_____	_____
Swelling, chronic-leg	_____	_____
Tuberculosis	_____	_____
Ulcers, skin	_____	_____
Ulcers, stomach	_____	_____
Varicose veins	_____	_____
Venereal disease	_____	_____
Weight loss, unexplained	_____	_____

LIST ALL SURGERIES (major and minor):

(1)_____

(2)_____

(3)_____

LIST ANY HOSPITALIZATIONS:

(1)_____

(2)_____

(3)_____

PATIENT CONSENT: I certify the above information is true and correct to the best of my knowledge. I also give my permission for IVAN J. NOSACEK, D.P.M. to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle problem(s).

Patient's Signature (or that of Parent or Guardian)_____ Date:____/_____/_____

Podiatrist Notes:

❑ Reviewed – No Changes ❑ Reviewed – Pertinent Changes, see dictated note

Signature: Date Reviewed:_____/_____/_____

Podiatrist Notes:

❑ Reviewed – No Changes ❑ Reviewed – Pertinent Changes, see dictated note

Signature: Date Reviewed:_____/_____/_____