Dr. Neal Blitz
Reconstructive Foot Surgery

120 East 56th Street, #800
New York, NY 10022

Todays Date:		
PATIENT INFORMATION		
Last Name:	**First Name:**	**MI:**
Date of Birth:	**Age:**	**Sex:** ☐ Female ☐ Male
Street Address:		**APT #:**
City:	**State:**	**Zip:**
Home #:	**Cell #:**	**Work #:**
Email Address:		**Social Security #:**
Occupation:		**Employer:**

REFERRAL INFORMATION		
Name of Primary Care Provider:		
Address of Primary Care Provider:		
Phone of Primary Care Provider:		**Fax of Primary Care Provider:**
Who Referred you to us? *Circle one*		
☐ Friend	☐ Close to job	☐ Physician:
☐ Family	☐Close to home	☐ Internet:
☐ Insurance Plan	☐ Hospital	☐ Other:

INSURANCE INFORMATION (Please give your insurance card to the receptionist)	
Primary Insurance:	**ID #**
Secondary Insurance:	**ID #**

EMERGENCY CONTACT INFORMATION		
Name:	**Relationship to Patient:**	**Phone:**

PHARMACY INFORMATION	
Name of Pharmacy:	**Phone of Pharmacy:**
Location of Pharmacy:	

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MEDICAL HISTORY

(check all that apply)

☐High Blood Pressure	☐ High Cholesterol	☐ Arthritis
☐ Heart Disease	☐ Thyriod Disease	☐ Rheumatoid Arthritis
☐ Heart Attack	☐ Liver Problems	☐ Bleeding Problems/Disorder
☐ Heart Murmur	☐ Hepatitis	☐ Fibromyalgia
☐ HIV / AIDS	☐ Diabetes	☐ Cancer:
☐ Stomach Ulcers / Reflux	☐ Asthma	☐ Neurologic Problems:
☐ Other:		☐ Psychiatric Problems:
		☐ Skin Problems:

PAST SURGICAL HISTORY

(check all that apply)

☐ Joint Replacement:	☐ Gall Bladder
	☐ Appendix
☐ Fracture Surgery:	☐ C-section
	☐ Heart Surgery
☐ Surgery for Circulation:	☐ Other:

MEDICATIONS

(include any over-the-counter medications)

Have you ever been put to sleep for surgery? ☐ No ☐Yes

Have you or any memember of your family had problems with anesthesia? ☐ No ☐Yes

ALLERGIES *(indicate the reaction)*

☐ **No Allergies**	☐ Foods	☐ Anti-inflammatories	☐Shellfish
☐ Penicillin	☐ Tape	☐ Codeine	☐ Other:
☐ Sulfa	☐ Latex	☐ Idoine	

SOCIAL HISTORY

Marital Status:	**Living Arrangement:**	**Use of Tobacco:** ☐ No ☐Yes
☐ Single	Live alone: ☐ No ☐Yes	Quit? How long ago:
☐ Married	Elevator: ☐ No ☐Yes	Smoke? packs per day
☐ Partnered	Stairs: ☐ No ☐Yes	**Use of Alcohol:** ☐ No ☐Yes
☐ Divorced	Pets: ☐ No ☐Yes:	☐occasional ☐social ☐daily
☐ Widowed	Young Kids: ☐ No ☐Yes	**Drugs Use:** ☐ No ☐Yes

Do you Exercise? ☐ No ☐Yes, describe:

FAMILY HISTORY

☐Stroke	☐Heart Disease	☐Diabetes	☐Rheumatoid Arthritis
☐Cancer	☐High Blood Pressure	☐Thyroid Problems	☐Other:

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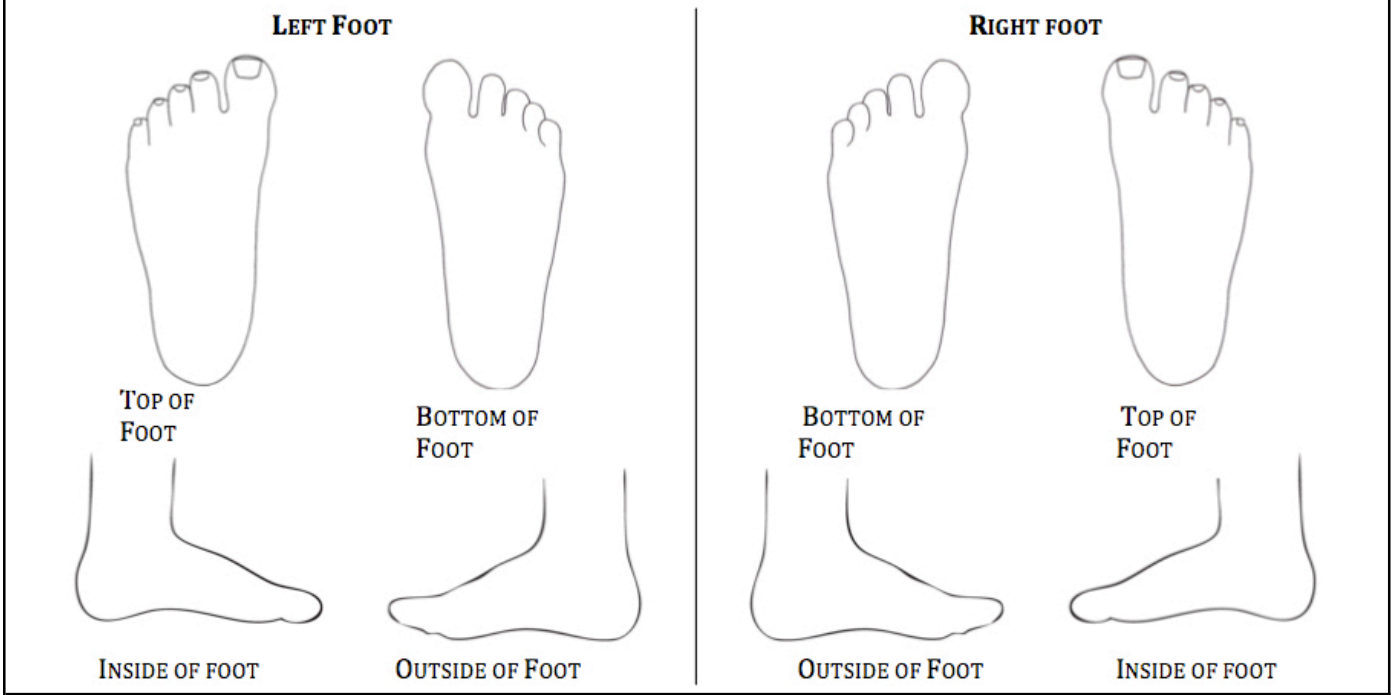
FOOT & ANKLE PROBLEM

How tall are you? | **How much do you weigh?**

Where is the problem on your foot? Please mark the pictures below



How long ago did this problem start? ☐Days: ☐Months: ☐Years:

How did the problem/pain start? ☐Suddenly ☐ Gradually over time

How would you rate the pain on a scale of 1 - 10?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

How would you describe the pain/discomfort? (check all that apply)

☐None ☐Sharp ☐Dull ☐Aching ☐Burning ☐ Other:
☐Radiating ☐Itching ☐Stabbing ☐Throbbing ☐Tingling

What makes the pain better?

What makes the pain worse? ☐walking ☐ standing ☐ daily activities ☐other:

What treatments have you tried?

Was this probem cause by an injury? ☐ No ☐Yes: Work injury? ☐ No ☐Yes

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ADDITIONAL INFORMATION

Any additional information that you want to include for the doctor?

To the best of my knowledge, I have answered the questions on this form accurately.
I understand that providing incorrect information can be dangerous to my health.
I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____

Print Name of Patient, Parent or Guardian

_____ _____

If Other than Patient, Relationship to Patient **Name of Doctor**

_____ _____

Signature **Date** **Sigature of Doctor**