ACCESS FOOT SPECIALISTS PODIATRY CLINIC

Patient Medical Questionnaire

Name____ Date____________________

Reason for Visit____

Present Patient Medical Problems____

Family History of Cancer: Circle : YES or NO and if yes please explain__________

____

Medications currently taking AND Allergies___________________________________

____

Have you ever had surgery? If yes, please list type of surgery and date that it was

performed____

Have you ever been hospitalized? If yes, specify the reason for hospitalization and

approximate dates____

Please **check** all medical problems listed that you have had past or present:

History of Back Pain____________Heart Disease______ Diabetes____

High Blood Pressure____________Skin Disease_______ Arthritis____

Stomach Ulcers__________Kidney Disease_____Liver Disease______

Bone or Joint Disease_____

Patient Email Address____

Signature____Date____________________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy, have viewed an electronic copy, or that I can request a copy in the medical office of the Notice of Privacy Practices. I acknowledge that I have read and understood the notice.

Printed Name:____

Signature:____Date_____________________