Daniel J. Walters D.P.M.,P.C

Patient Information (Please Print)

Last Name _____ First Name_____

Address_____City,State,zip_____

Home Phone( )_____Work( )_____Cell( )_____

Birthday_____Age_____ Sex_____F_____M Marital Status S, M, D, W._____

Emergency Contact:_____Phone_____

How did you hear about our office?_____

Social Security Number_____Email_____

If the patient is a minor who is the responsible party?_____

Are you a Smoker_____ Non-Smoker_____ Ever Smoked before_____

Medical History

Have you been seen or treated by a physician in the past month?_____

Are you currently taking any prescription medication? (Please List)_____

_____

Are you allergic to any medications or foods? (if so please list)_____

_____

Have you had any surgery in the past 6 months?_____

When was your last flu shot?_____

When was your last Pneumonia Vaccination? _____

When was your last Lipoprotein (LDL-C) Test Performed? _____

Do you consume Alcohol? YES_____ or NO_____. If yes how often?_____

Are you a Diabetic? YES or NO : IF yes when was your Diabetic eye exam?_____

If you are Diabetic when was the your last Hemoglobin A1c blood test? _____

What was the percentage of that blood test? _____

Have you ever had or been treated for the following? (check all that apply)

_____ High Blood Pressure _____Low Blood Pressure _____Cancer _____Stroke _____Ulcer

_____Circulation problems _____Back Problems _____Respiratory Disease

_____Artificial Heart, _____Arthritis _____Allergies to Anesthetics _____A.I.D.S