# ROCHESTER PODIATRY

Board Certified Physicians and Surgeons

## Massimo Pietrantoni, DPM

Date of Appointment _____ When did your foot /ankle issue start? _____

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Sex M F Birthdate _____

Home Phone ( ____ ) _____ Cell ( ____ ) _____ Work ( ____ ) _____

Emergency, Contact: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separate ☐ Partnered ☐ Minor

Occupation _____ Employer & address _____

Spouse/Partner Info: Name: _____ Occupation: _____ Birthdate: _____

How did you hear about our office?

☐ Doctor: _____ ☐ Google/Internet

☐ Insurance Website ☐ Facebook ☐ Family/Friend: _____

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Phone #: ( ____ ) _____

Primary Physician's Hospital Affiliation: ☐ RRH ☐ URMC ☐ Other

Preferred Local Pharmacy: _____

Address: _____

**Reason for todays visit**:

Do you need Antibiotics before Surgery/Dental Procedures? ☐ Yes ☐ No

Medications: ____ NONE

Surgeries: ____ NONE

Allergies: ____ NONE

☐ Adhesive/ tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ OTHER:

☐ Latex
☐ Local Anesthetics
☐ Penicillin
☐ Metal/Nickel
☐ Seafood
☐ Sulfa

Height _____ Weight _____
Shoe Size _____
Have you seen a Podiatrist in the past?
☐ Yes ☐ No
If Yes, Please List:
Name _____
Last Visit _____
Reason _____
_____

Social History:
Tobacco ___ Yes ___ No
Alcohol ___ Yes ___ No
Coffee/tea ___ Yes ___ No
Recreational drugs ___ Yes ___ No
I.V. Drugs ___ Yes ___ No
OTHER ___ Yes ___ No
_____
_____

Family History: ___ **NONE**

| | Mother | Father |
|---|---|---|
| Heart Disease | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Sickle Cell | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |

Other _____

## PODIATRIC HISTORY

| | Currently | Previously |
|---|---|---|
| Ankle Pain | ☐ | ☐ |
| Athlete's Foot | ☐ | ☐ |
| Bunions | ☐ | ☐ |
| Corns, Calluses | ☐ | ☐ |
| Numbness feet/legs | ☐ | ☐ |
| Flat feet | ☐ | ☐ |
| Use over the counter inserts | ☐ | ☐ |
| Use Custom orthotics | ☐ | ☐ |
| Heel Pain | ☐ | ☐ |
| Ingrown toenails | ☐ | ☐ |
| Plantar warts | ☐ | ☐ |
| Foot Ulcers | ☐ | ☐ |

## MEDICAL HISTORY

| | Yes | No |
|---|---|---|
| AIDS/HIV | ☐ | ☐ |
| Anemia Type _____ | ☐ | ☐ |
| Angina | ☐ | ☐ |
| Arthritis Type _____ | ☐ | ☐ |
| Artificial heart valves | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Back Problems | ☐ | ☐ |
| Bleed Disorders | ☐ | ☐ |
| Cancer Type _____ | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Cholesterol | ☐ | ☐ |
| Circulatory issues (PVD) | ☐ | ☐ |
| Diabetes ___Type I ___Type II | ☐ | ☐ |
| Ear Problems | ☐ | ☐ |
| Eye Problems | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Heart disease | ☐ | ☐ |
| Hepatitis Type ____ What Year ____ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Implants Type _____ | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Low back Disc/Nerve Issue | ☐ | ☐ |
| M.S (Multiple Sclerosis) | ☐ | ☐ |
| Neuropathy/Numbness | ☐ | ☐ |
| Phlebitis | ☐ | ☐ |
| Prior Blood Clts/DVT | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |
| Psychiatric Care | ☐ | ☐ |
| Rash/Dermatitis | ☐ | ☐ |
| Respratory/Lung Disease | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Scleroderma | ☐ | ☐ |
| Special Diet | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ |
| Tuberulosis (TB) | ☐ | ☐ |
| Ulcers (Stomach/G.I) | ☐ | ☐ |
| Varicose Veins | ☐ | ☐ |

OTHER: _____
_____

Are you now, or have you been under the care of any doctor (other than your primary care physician) for any reason over the last two years? Yes No If yes, Who & reason?

## Treatment and Insurance Consent

I hereby consent and give my permission to Rochester Podiatry, its healthcare providers, assistants and/or designated replacement to administer and perform such procedures and treatments upon me as the they deem necessary. I give consent for Rochester Podiatry to bill my insurance and collect payment for rendered services.

Signature of Patient or Guardian: _____ Date: _____