Les J. Glubo, DPM

Patient's Name________________________________ Home Phone________________________________

Address________________________________ City__________ State________ Zip________________

Birth Date____________ Age________ _____Male _____Female Social Security________________

Marital Status: _______S _____M _____D ______W

Employer ________________________ Business Phone______________ Cell Phone______________

E-mail address ________________________________

Medical Insurance Information

Primary Insurance Co. __________________________ Name of Insured____________________

Insured's Date of Birth__________________________ Relationship to Insured ______________

Insured's Employer ____________________________ Secondary Insurance Co.______________

Medical History

Reason for seeing doctor today____

____

Previous foot, ankle or leg problems/ injury / surgery_____________________________

____

List Any Other Operations & Dates____

____

Do you Smoke? __________No __________Yes __________Packs per day

Have you ever had or been treated for the following?

____Psoriasis	____High Blood Pressure	____Gout	____Diabetes
____Asthma	____Rheumatic Fever	____Poor Circulation	____Bleeding Tendencies
____Pneumonia	____Stomach Ulcers	____Varicose Veins	____Kidney Problems
____Tuberculosis	____Hepatitis	____Blood Clots	____Aids or Related
____Heart Problems	____Arthritis	____Epilepsy	____Other

____

Current Medications____

____

Are you allergic to any medications? ______No ______Yes (Please specify below)

____Penicillin	____Codeine	_____Cortisone	_____Anesthetics / Novacain
____Vicodin	____Demerol	_____Aspirin	_____Iodine / Betadine ___Other

____

Any other Pertinent Medical / Family History of Information?_______________________

____

Primary Care Physician____

Address______________________________ City____________________ Zip__________

Referred By____

_____Doctor____________________ Address____________________ City________ Zip______

_____Patient or Friend (please list)____

_____Internet _____Phone Book / Yellow pages _____Other____________________

Signature________________________________ Date______________________________

Practice Name: **Chart Number:**

Name: ______________________ **Date of birth:** ______________________

Race: ______________________ ☐I prefer not to answer ☐I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: ______________________ ☐I prefer not to answer ☐I do not know

Preferred Language: ______________________ ☐I prefer not to answer

Privacy Information Preferences

Did you receive a copy of the HIPAA Privacy Practice Notice: ☐Yes ☐ No

Do you want to be exempt from public reporting? ☐Yes ☐No

May we send mail to the address on file? ☐Yes ☐No

May we call the phone number on file? ☐Yes ☐No

May we leave voicemail on answering machine? ☐Yes ☐No

Will you allow internet based delivery reminders like email? ☐Yes ☐No

Who may we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son

☐ Other: ____________

Smoking Status

- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ I decline to answer
- ☐ Smoker, Current status unknown
- ☐ Unknown if ever smoked

Vital Signs

Blood Pressure: ________ / ________

Height: ____________

Weight: ____________

☐I prefer not to answer ☐I do not know

Current Medications

____

____

____

____

☐ I am not taking medication ☐ I prefer not to answer

Allergies

____

____

____

____

☐ I do not have allergies ☐ I prefer not to answer