Eastside Foot & Ankle Clinic, P.C.

David H. Berlin, DPM

Board Certified Surgeon

Today's Date: ______________

Welcome To Our Office

Name: ______________________________ Sex: M F

Address: ______________ City: ______________ State: ______ Zip: ______

Social Security #: ______________ Birth date: ______________

Home Phone #: ______________ Cell/Alt #: ______________

Can we leave voice messages? yes no Can we send text messages to your cell phone? yes no

Email: ______________ How did you hear about us? ______________

Marital Status: S M D W Spouse's name: ______________

Your Employer: ______________ Name of Insurance: ______________

IF DIFFERENT FROM ABOVE

Insured Name: ______________ Insured Birth date: ______________

Insured Employer: ______________ Insured Social Security#: ______________

Emergency Contact Name: ______________________________

Emergency Contact #: ______________ Relation to you: ______________

What is your preferred language? ______________

Ethnicity ?
- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino

Race?
- ◯ African or African American
- ◯ Asian or Asian American
- ◯ Caucasian or European American
- ◯ Native American or Native Alaskan
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other race ______________

Are you a current smoker? .... ◯ No
◯ Yes... How much? ____________________

Are you a former smoker .... ◯ No
◯ Yes... When did you quit? ______________ How long did you smoke? ____________

Do you drink alcohol? .... ◯ No
◯ Yes... How much? ____________________

Do you bruise easily? .... ◯ No ◯ Yes

Do you have back pain? .... ◯ No ◯ Yes

Are you subject to prolonged bleeding or delayed healing?.... ◯ No ◯ Yes

Any possibility your pregnant?.. ◯ No ◯ Yes

Height: ______________ Weight: ______________ Shoe Size: ________________

When was your last tetanus shot? ________________

What is your major complaint today?
◯ Pain ◯ Injury ◯ Wart ◯ Diabetic Check
◯ Corn ◯ Bunion ◯ Hammertoe ◯ Ingrown Toenail
◯ Mass ◯ Swelling ◯ Toenail Fungus ◯ Skin Disorder
◯ Tough Toenails ◯ Other ________________________

Location of your complaint?

Ankle:	◯R	◯L	Arch:	◯R	◯L
Ball:	◯R	◯L	Heel:	◯R	◯L
Top of Foot:	◯R	◯L	Toe(s):	◯R	◯L

Other ____

How long have you had this problem? ____

Have you been treated in the past for this problem? ◯ No ◯ Yes If yes, by whom? ________________________

If yes, what was the treatment? ____

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ALLERGIES AND REACTIONS

ALLERGY	REACTION
◯ Adhesives	
◯ Antihistamines	
◯ Aspirin	
◯ Betadine	
◯ Codeine	
◯ Cortisone	
◯ Latex	
◯ Penicillin	
◯ Sulfa	
◯ Tylenol	
◯ Xylocaine	
◯ **OTHER**	
◯	
◯	
◯ **I HAVE NO ALLERGIES**	

MEDICATIONS

MEDICATION	DOSE	TIMES/DAY

MEDICAL CONDITIONS

ME	FAMILY	YEAR	
◯	◯		Rheumatoid Arthritis
◯	◯		Osteoarthritis
◯	◯		Artificial Hip / Right or Left?
◯	◯		Artificial Knee / Right or Left?
◯	◯		Sciatica
◯	◯		Low Blood Pressure
◯	◯		High Blood Pressure
◯	◯		Active Cancer: type?______________
◯	◯		Cancer in remission: type?__________
◯	◯		Anemia
◯	◯		Aneurysm
◯	◯		Bleed Easily
◯	◯		Blood Clots
◯	◯		Hemophilia
◯	◯		Peripheral Vascular/Artery Disease
◯	◯		Venous Insufficiency
◯	◯		Phlebitis
◯	◯		Varicose Veins
◯	◯		Asthma
◯	◯		COPD
◯	◯		Emphysema
◯	◯		Tuberculosis
◯	◯		Eczema
◯	◯		Excessive Perspiration
◯	◯		Psoriasis
◯	◯		Warts

ME	FAMILY	YEAR	
◯	◯		Diabetes
◯	◯		Do you take Insulin?
◯	◯		Angina
◯	◯		Arteriosclerosis
◯	◯		Chronic Heart Failure (CHF)
◯	◯		Mitral Valve Prolapse
◯	◯		Myocardial Infarction
◯	◯		Pacemaker
◯	◯		Heart Attack
◯	◯		Stents
◯	◯		Hepatitis: Type? A B C
◯	◯		AIDS/HIV
◯	◯		Any communicable disease
◯	◯		Fibromyalgia
◯	◯		Lupus
◯	◯		Gullian Barre
◯	◯		Multiple Sclerosis
◯	◯		Parkinson
◯	◯		Polio
◯	◯		Sickle Cell and Trait
◯	◯		Stroke
◯	◯		Neuropathy
◯	◯		Underactive Thyroid
◯	◯		Overactive Thyroid
◯	◯		
◯	◯		

PLEASE LIST ALL SURGERIES AND DATE PERFORMED

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Primary Care Physician's Name: ____

Physician's Address:____

Phone#:______________________________

Pharmacy Name: ____

Phone#:______________________________

Pharmacy Address or crossroads:____

Is there anything else we should know?____

I hereby authorize assignment of benefits to be paid directly to Dr. David H. Berlin, DPM. This assignment will remain in effect until revoked by me in writing. I understand I am responsible for obtaining all needed referrals. I also agree to pay, in full, all fees regardless of insurance coverage; including deductible, co-insurance costs and any services which are determined to be "not covered" or "denied". I give Dr. Berlin permission to release any information requested by my insurance in the course of my treatment. I also give permission for Dr. Berlin, DPM to perform such general procedures as he may deem necessary in the diagnosis and treatment of my condition. A photocopy of this agreement shall be considered valid as an original.

Patient / Guardian Signature:____

Date:______________________________