David J. Valvo, DPM PC

WELCOME TO OUR PRACTICE

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ DATE OF BIRTH _____ AGE_____

EMPLOYER _____ OCCUPATION _____ WORK # _____

GENDER AT BIRTH _____ MARITAL STATUS _____

Referred By _____ Primary Care Doctor: _____

IS YOUR PROBLEM A MOTOR VEHICLE ACCIDENT OR WORKER'S COMP CASE? _____

HEALTH HISTORY

WHAT IS YOUR FOOT PROBLEM _____

PLEASE CIRCLE: LEFT FOOT RIGHT FOOT BOTH FEET DURATION _____

PLEASE CHECK BELOW IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

_____ High Blood Pressure	_____ Diabetes	_____ Heart Disease
_____ Thyroid Problems	_____ Asthma	_____ Tuberculosis
_____ Stomach Disorders	_____ Cancer	_____ Arthritis
_____ Rheumatic Fever	_____ Neurologic Disorders	_____ Skin Disease
_____ Phlebitis	_____ Psychiatric Disorders	_____ Gout
_____ Kidney Disease	_____ Eye disease	_____ Epilepsy
_____ Liver Disease	_____ High Cholesterol	_____ Blood Clots

ARE YOU CURRENTLY PREGNANT? YES _____ NO _____ BIRTH CONTROL PILLS? _____

DO YOU SMOKE? YES _____ NO _____ HOW MUCH DO YOU SMOKE? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES _____ NO _____ PURPOSE? _____

ALLERGIES TO MEDS: _____

LIST **ALL** SURGERIES: _____

_____

PLEASE LIST ALL MEDICATIONS ON THE PAGE PROVIDED