Gresham Podiatry Center, LLC

831 N.W. Council Drive, Suite 203 ▪ Gresham, Oregon 97030 ▪ Phone: (503) 667-6600

PATIENT NAME: ____________________

PHARMACY YOU LIKE TO USE: ____________________ PHONE: ____________________

PREVIOUS TREATMENT BY PODIATRIST: ☐ YES ☐ NO

WHEN: ____________________ WHO: ____________________

WHY ARE WE SEEING YOU TODAY? / WHEN DID IT START AND HOW? / PRIOR TREATMENTS? ____________________

____

DID YOU INJURE YOURSELF AT WORK? ____________________

ARE YOU A DIABETIC? ☐ YES ☐ NO WHEN WERE YOU DIAGNOSED? ____________________

IF SO, ☐ DIET CONTROLLED ☐ ORAL MEDICATION ☐ INSULIN DEPENDENT

BLOOD SUGAR RANGE = ____________________ DO YOU KNOW YOUR HgbA1c VALUE? ____________________

CURRENT OR PAST ILLNESS (PLEASE CIRCLE)

HEART DISEASE	LOW BACK PAIN	ASTHMA
ARTHRITIS	VARICOSE VEINS	LIVER TROUBLE
BLOOD DISEASE	TUBERCULOSIS	CANCER – WHAT TYPE ____________
GOUT	EYE TROUBLE	BLOOD CLOTS
HIGH BLOOD PRESSURE	RHEUMATIC FEVER	

OTHER: ____________________

HEIGHT ____________ WEIGHT ____________LBS

PAST OPERATIONS: ____________________

MEDICATIONS YOU NOW USE (INCLUDE ASPIRIN, VITAMINS, HERBS, ETC.): ____________________

____

WHAT ARE YOU ALLERGIC TO? (Please check box and note your reaction.) ☐ NOTHING KNOWN

☐ NOVOCAINE ____________________ ☐ PENICILLIN ____________________

☐ ADHESIVE TAPE ____________________ ☐ MATERIALS ____________________

☐ SULFA ____________________ ☐ FOODS: ____________________

☐ OTHER: ____________________

DO YOU SMOKE? ☐ YES ☐ NO IF SO, AGE STARTED ________ HOW MUCH ____________________

I HEREBY GIVE PERMISSION TO GRESHAM PODIATRY CENTER, LLC TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN MY DIAGNOSIS AND / OR TREATMENT.

DATE: ____________________ SIGNATURE: ____________________