PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: M F

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE # : ( ) - YES NO

WORK PHONE # : ( ) - YES NO

CELL PHONE # : ( ) - YES NO

EMAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

- IF YES, NAME: _____ RELATIONSHIP: _____ PHONE: (_____) _____ - _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE: (_____) _____ - _____

PRIMARY CARE DOCTOR

NAME: _____ PHONE: (_____)_____-_____

SOCIAL HISTORY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____

☐ SMOKE _____ PACKS/DAY FOR _____YEARS

EMPLOYER: _____ OCCUPATION: _____

PATIENT NAME: _____
DATE of BIRTH: _____/_____/_____

YOUR MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS
WAS THE ONSET OF PAIN (CHECK ONE) _____ SUDDEN _____ GRADUAL

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*
IS THE PAIN _____ CONSTANT _____ COMES AND GOES
IS THE PAIN THE RESULT OF AN INJURY (CIRCLE ONE) Y N
HOW HAVE YOU BEEN TREATING THE PAIN _____
_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Revised June 2015

Philip R. Shupe, DPM, FACFAS
1530 E Chevy Chase Dr., #107
Glendale, CA 91206
(818) 265-1581

Dear Patient,

As of January 1, 2022, there is a new Federal mandate that will require all drug prescriptions to be sent electronically to pharmacies. Paper and faxed prescriptions will no longer be permitted.

Please fill out your pharmacy and personal information below.

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

Patient Name (Print): _____

Patient Address: _____

_____

Patient Phone Number: _____

Patient DOB: _____

Patient Signature: _____

Date: _____

Thank you!

Philip R. Shupe, DPM

MY MEDICATION LIST

Patient Name: _____ Date: _____

Date of Birth: _____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. ***Bring this list with you to your first appointment.***

Drug Name	Drug Strength	Amount and Times of Day Taken	Reason for Medication	Prescriber

Do you have any allergies? _____ Yes _____ No

If yes, please list:

_____

_____

PHILIP R. SHUPE, DPM, FACFAS
Podiatric Medicine and Surgery

Diplomate, American Board of Podiatric Surgery
Board Certified in Foot & Ankle Surgery

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INSURANCE WAIVER

I, _____
understand and agree that in the event my insurance coverage and benefits cannot be verified. It is my sole responsibility to pay for all services rendered to me by Philip R. Shupe, DPM.

I also understand and agree to pay for today's office visit (including labs if applicable), should it not be a covered benefit under my health insurance plan and that any specialist copay is due at the time of the office visit. I further understand that lab charges are separate from the charges of a doctor's visit.

_____
Patient's Signature

_____
Date