Dr Russell M Blatstein

(772) 225 – 3668
1635 NE Jensen Beach Blvd
Jensen Beach, FL 34957

(772) 337 – 2920
1226 SE Port St Lucie Blvd
Port St Lucie, FL 34952

PATIENT MEDICAL INFORMATION

First Name:____________________ MI:________ Last Name:_______________________

Shoe Size:__________ Weight:__________ Height:__________

Preferred Pharmacy:____________________
Street/City:___________________________
Phone: (_______)___________________

Past History:

Do you have or have you ever been treated for:

☐Anemia ☐Angina ☐Ankle Injury
☐Anxiety ☐Arch Pain ☐Asthma
☐Broken Foot Bone(s) ☐Bunions ☐Calluses
☐Childhood FootProblem ☐Corns ☐Cancer
☐Chron's Disease ☐Cataracts ☐ Colitis
☐Depression ☐Diabetes ☐Emphysema
☐Flat Feet ☐Glaucoma ☐Gout
☐High Cholesterol ☐Heart Murmur ☐Heart Attack
☐Heart Disease ☐Heart Problems ☐Heel Pain
☐Hypothyroidism ☐High Arch Feet ☐HIV/AIDS
☐High Blood Pressure ☐Hammertoes ☐Ingrown Nails
☐Jaundice ☐Kidney Disease ☐Knee Pain
☐Kidney Stones ☐Leukemia ☐Lung Disease
☐Liver Disease ☐Low Back Pain ☐Neuroma
☐Nerve Disorder ☐Phlebitis ☐Pneumonia
☐Pulmonary Embolism ☐Rash ☐Psychiatric Disorder
☐Rheumatic Fever ☐Scarlet Fever ☐ Trauma
☐Stomach/Peptic Ulcer ☐Tuberculosis ☐Thyroid Problems
☐Stroke Epilepsy (seizures) ☐Other______________________

Have you ever had a Blood transfusion Y / N
If so, When? ____________________

Have you ever been exposed to Hepatitis Y / N Type A / B / C
If so, When? ____________________ Were you treated? Y / N

Are you currently pregnant? ☐YES ☐NO
Are you now under active chemotherapy? ☐YES ☐NO
Do your feet hurt at night? ☐YES ☐NO
Do you have any difficulty in walking? ☐YES ☐NO
Do you get leg cramps? ☐YES ☐NO
Any pain in calves or buttocks while walking? ☐YES ☐NO
Is the pain relieved by rest? ☐YES ☐NO
Are you slow to heal after cuts? ☐YES ☐NO
Any abnormal bruising or bleeding? ☐YES ☐NO
Do you have vascular grafts? (please explain) ☐YES ☐NO
Do you have joint implants? (please explain) ☐YES ☐NO
Do you have replacement heart valves? ☐YES ☐NO
Have you had any other serious medical illness?(list)☐YES ☐NO
Have you ever been hospitalized or been under medical care for very long? (please explain) ☐YES ☐NO
Have you ever had surgery? (if yes, please list) ☐YES ☐NO

Surgery/Hospitalizations?	Date of?	W/complications of?
__________________	__________	________________
__________________	__________	________________
__________________	__________	________________

Explanations:____
____
____

Family History:

List anyone in your family who have or had any of the following? (father, mother, siblings, child, maternal grandmother, maternal grandfather, paternal grandmother, paternal grandfather)

Arthritis _______________ Hypertension _______________
Cancer _______________ Diabetes Type II _______________
Stroke _______________ Alzheimer's _______________
Depression _______________ Osteoporosis _______________
Heart Attack _______________ Foot Problems _______________
Birth Defects_______________ Domestic Violence_______________
Coronary Artery Disease _______________

Social History:

Lives with: Alone / Spouse / Children / Others _______________
Children: Y / N 0 / 1 / 2 / 3 / 4 / 5 / _________
Pets: Y / N List: ______________________________________
Do you live in any of the following:
Assisted Living Facility / Retirement Community / Nursing Home

Occupational Hazards? Y / N (If yes, please circle one)
Stress Heavy lifting Hazardous substances Excessive standing
. Other_________________

What percentage of your hours awake are you on your feet?(circle one)
20% 40% 60% 80% 100%

List the sports/type of dance you are active in:
____

Current Tobacco Use? Y / N #Packs/Day ____ How many years _____
Past Smoker? Y / N #Packs/Day ____ Years _____ Date quit________

Exercise? Y / N How much per day?____Per week?________
Caffeine? Y / N How much per day?____Per week?________
Alcohol Intake? Y / N How much per day?____Per week?________
Recreational drugs? Y / N What kind?__________How much? ________

Have you ever seen a Podiatrist before? Y / N
If yes, Dr. Name _____________________ Last seen: ________________

Have you ever worn orthotics/arch supports? Y / N
What kind? Over the counter / custom / ____________________________

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Allergies:

If not allergic to anything please circle → **NO KNOWN ALLERGIES**

If there is a history of skin reaction, other outward reaction or sickness following an injection, oral or topical administration of?
If yes, please check box and list reaction (ie: Anaphylaxis Shock, Difficulty Breathing, Difficulty Swallowing, Hives/Rash, Nausea/Vomiting, Diarrhea or Other).

	No	***Unsure***	***Mild***	***Moderate***	***Severe***
Penicillin or other antibiotics………………	☐	☐	☐	☐	☐
If yes, what happens?____________________					
Morphine, Codeine, Demerol, other Narcotic	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Novocaine or other Anesthetics……………...	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Aspirin, Empirin or other pain remedies…….	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Sulfa drugs……………………………………	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Adhesive Tape……………………………..…	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Iodine or Merthiolate………………………....	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Latex…………………………………………	☐	☐	☐	☐	☐
If yes, what happens? ____________________					
Any other Drug, medication or treatment……	☐	☐	☐	☐	☐
If yes, List:_________________________What happens?__________________________					
Other Allergy?__________________________	☐	☐	☐	☐	☐

Patient Physicians:

Please list the Names, Phone numbers, and Cities of all other doctors that you currently or have recently seen:

Family/Primary ______________________________
Phone Number (______)______-_______________
City, State ______________________________

Specialist ______________________________
Phone Number (______)______-_______________
City, State ______________________________

Specialist ______________________________
Phone Number (______)______-_______________
City, State ______________________________

Chiropractor ______________________________
Phone Number (______)______-_______________
City, State ______________________________

Other Podiatrist ______________________________
Phone Number (______)______-_______________
City, State ______________________________

Other ______________________________
Phone Number (______)______-_______________
City, State ______________________________

Medications:

If you have your medications on a list we can make a copy. Your Pharmacy can give you a copy of all the medications you are currently taking.
Please list all medications including Prescriptions/ Vitamins/Over the counter medicines/Supplements/Herbs

Are you currently taking Insulin? Y / N
Are you currently taking any other medications, vitamins, dietary supplements, over the counter medicines? Y / N

Name of Medication	Dosage	Taken How Often	Prescribing Doctor	Taking for what condition
EXAMPLE:: ASPIRIN	*325mg*	*1 morning, 1 evening*	*DR BLATSTEIN*	*PAIN*

I hereby certify that all the statements and information provided on this form are true and accurate to the best of my knowledge and belief.

X____**Date**_____/_____/_____
Signed by Parent or other legally responsible person

X____**Date**_____/_____/_____
Signed by Patient (Parent must also sign if patient is under 18 years of age