J O H N F . T O R R E G R O S A , D . P . M . ,
F . A . C . F . A . S . , F . A . C . F . A . O . M .
A N K L E A N D F O O T S U R G E R Y

NEW PATIENT HISTORY FORM

Please take a moment to answer the following questions as thoroughly and as accurately as possible. Thank you.

Patient Name: _____Date: _____

Date of Birth: _____Age: _____ Sex: M F Occupation: _____

Height: _____ Weight: _____

Reason for your visit: _____

Whom may we thank for referring you? _____

Who is your primary doctor? _____

If female, are you or could you be pregnant? ¡ Yes ¡ No

Was your injury sustained at work? ¡ Yes ¡ No If yes is it Worker's Comp? ¡Yes ¡ No

Is this injury the subject of litigation? ¡ Yes ¡ No

Are you currently working? ¡ Yes ¡ No

If no, when did you last work? _____

Please list *ALL* current and past medical illnesses/problems:

_____

_____

_____

Please list *ALL* previous surgeries/procedures:

_____
_____
_____
_____
_____

_____ _____

Patient or Legal Guardian John F. Torregrosa, D.P.M.

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NEW PATIENT HISTORY FORM
PAGE 2

Patient Name: _____Date:_____

Please list *ALL* current medications, including vitamins/supplements:

Name of Medication	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any illnesses that run in your immediate family (i.e. parents, siblings):

Please list any *ALLERGIES* to medications, foods, contrasts, or dye:

Do you smoke? _____ If yes, how many pack(s)____/day, for_____years Quit____years ago

Do you drink beer, liquor, or wine? _____ If yes, how much and how often? _____

Do you currently use any illicit drugs? ¡ Yes ¡ No If yes, please list_____

Can you take Aspirin? ¡ Yes ¡ No

Have you ever had stomach ulcers? ¡ Yes ¡ No

Have you taken a Steroid medication (e.g., Prednisone, Cortisone) within the past 6 months ?
¡ Yes ¡ No

Do you require Antibiotics before dental procedures (i.e., antibiotic prophylaxis)? ¡ Yes ¡ No

Have you ever been treated for nervous or emotional problems? ¡ Yes ¡ No

Have you ever had or been treated for KIDNEY PROBLEMS?

Y	**N**	**Kidney failure**	**Y**	**N**	**Stones/Calculi**
Y	**N**	**Pain with urination**	**Y**	**N**	**Blood in urine**
Y	**N**	**Incontinence**			

_____ _____
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NEW PATIENT HISTORY FORM
PAGE 3

Have you ever had or been treated for HEART PROBLEMS?

Y	**N**	**Chest pain/Angina**			
Y	**N**	**Heart Attack**	**Y**	**N**	**Murmur**
Y	**N**	**Stroke**	**Y**	**N**	**Irregular heart beat**
Y	**N**	**Heart failure**	**Y**	**N**	**High blood pressure**
Y	**N**	**Palpitations**	**Y**	**N**	**Low blood pressure**

Have you ever had or been treated for LUNG PROBLEMS?

Y	**N**	**Asthma**	**Y**	**N**	**Wheezing**
Y	**N**	**Bronchitis/Chronic cough**	**Y**	**N**	**Emphysema**
Y	**N**	**Pneumonia**	**Y**	**N**	**Tuberculosis**
Y	**N**	**Shortness of breath**			

Have you ever had or been treated for DIGESTIVE TRACT PROBLEMS?

Y	**N**	**Ulcer disease/Gastritis**	**Y**	**N**	**Chronic indigestion**
Y	**N**	**Reflux**	**Y**	**N**	**Hernia**
Y	**N**	**Hepatitis/Jaundice**	**Y**	**N**	**Liver problems/Cirrhosis**
Y	**N**	**Gall bladder problems**	**Y**	**N**	**Pancreatitis**

Have you ever had or been treated for METABOLIC or ENDOCRINE PROBLEMS?

Y	**N**	**Diabetes**	**Y**	**N**	**Low blood sugar**
Y	**N**	**Thyroid disease**	**Y**	**N**	**Fatigue**
Y	**N**	**Weight loss/gain**	**Y**	**N**	**Fainting**

Have you ever had or been treated for PROLONGED BLEEDING or EASY BRUISING?

Y N

Have you ever had or been treated for NEUROLOGICAL PROBLEMS?

Y	**N**	**Convulsions/Epilepsy**
Y	**N**	**Numbness/Tingling in arms or legs**
Y	**N**	**Blurred/Double vision**
Y	**N**	**Low back pain/Sciatica**
Y	**N**	**Muscle weakness**
Y	**N**	**Spasms**

Have you ever had or been treated for MUSCLE, BONE, JOINT PROBLEMS?

Y	**N**	**Arthritis**
Y	**N**	**Osteoporosis**
Y	**N**	**Muscle pains**

_____ _____

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