Welcome to my office

Patient's Full Legal Name:_____
Street Address:_____
City:_____ State: _____Zip:_____
Mailing address if different from above: _____
City:_____ State: _____ Zip:_____

Patient Age:_____Date of Birth_____ Sex: Male Female
Marital Status: Single Married Divorced Separated Widowed Life Partner
Home phone number: _____ Cell number:_____
Driver's License #_____ Expiration Date: _____

Patient's Occupation_____ Employer_____
Work number:_____ May we call you at work: YES NO
Work Address:_____
City:_____ State: _____Zip:_____

Spouse/Partner Name: _____ Spouse/Partner's Employer's Name: _____
Work number:_____

If patient is a minor (under 18 years of age), or if you are legal guardian, please complete the following:
Responsible Party Name: _____Relationship to Patient: _____
Address: (if different from patient)_____ Date of Birth_____
City:_____ State: _____ Zip:_____
Driver's License Number: _____ Expiration date: _____
Home phone number: _____ Cell number:_____
Occupation_____ Employer_____
Work number:_____ May we call you at work: YES NO
Work Address:_____
City:_____ State: _____ Zip:_____

Person to contact in case of Emergency: _____
Relationship: _____ Phone number: _____

I engage Dr. Gennady Kolodenker to render medical care and service to: (Please circle one)
Myself My Child My legal charge

Patient Signature: _____Date: _____
Parent or Guardian
(if minor or other): _____Date: _____

A photocopy of this form shall be considered as effective and valid as the original

Gennady Kolodenker, DPM, AACFAS
Foot and Ankle Specialist
4950 Barranca Pkwy, Suite 308
Irvine, CA 92604
(949) 651-1202

Gennady Kolodenker, DPM, AACFAS

MEDICAL HISTORY

****

Name: _____ Date of Birth: _____/_____/_____

Please describe your present problem(s): _____

_____

How long have you had this problem? _____Days, _____Weeks, _____Months, _____Years

Have you had previous treatment for this problem? _____Yes _____No

If yes, by whom and when: _____

Family Physician: _____Last Visit Date: ___/_____/_____

Please check *Yes* or *No* to indicate if you have any of the following:											
	Y	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Aids/HIV			Circulatory problems			Hepatitis			Radiation treatment		
Allergies to anesthetics			Depression			High blood pressure			Respiratory disease		
Anemia			Diabetes			Jaundice			Rheumatic fever		
Angina			Dialysis			Kidney problems			Rheumatoid arthritis		
Arthritis			Ear problems			Liver disease			Sinus problems		
Artificial heart valves			Epilepsy			Low blood pressure			Skin cancer		
Artificial joints			Eye problems			Nervous problems			Stroke		
Asthma			Fainting			Neuropathy			Swollen neck glands		
Back problems			Glaucoma			Osteoporosis			Thyroid problems		
Bleeding disorders			Gout			Phlebitis			Tuberculosis		
Cancer, _____			Heart attack			Pneumonia			Ulcers		
Cataracts			Heart disease			Prostate problems			Varicose veins		
Chemical dependency			Heart surgery			Psoriasis			Venereal disease		
Chronic diarrhea			Hemophilia			Psychiatric care			Other, _____		

Previous Surgeries: *(Please list **all** prior surgeries and dates.)*

_____

_____

Previous Hospitalizations: *(Please list reason/dates for hospitalizations other than for above surgeries.)*

_____

_____

Medications: *(Please list **all** current medications including over-the-counter medications and oral contraceptives.)* _____

_____

_____

Family Medical History: *(Please list any significant family history.)*

_____

_____

Allergies: *(Please circle any allergies you have.)* _____*No known drug allergies*

Adhesive tape Aspirin Codeine Demerol Iodine Local Anesthetics

Penicillin Sulfa Other antibiotics_____ Other Medication_____

****

Smoking History: ( ) Never smoked ( ) Past smoker ( ) Current smoker, #/day_____

Alcohol Use: ( ) No ( ) Yes, how often/how many_____

Review of Body Systems

Please check if you have any of the following.

Eyes:	☐ Blurred vision	☐ Blindness			
Musculoskeletal:	☐ Pain	☐ Weakness	☐ Numbness	☐ Stiffness	☐ Swelling
	☐ Foot/Leg cramps				
Integument:	☐ Rashes	☐ Dry skin	☐ Itching		
Respiratory:	☐ Shortness of breath	☐ Wheezing	☐ Cough		
Cardiovascular:	☐ Chest pain	☐ Swelling ankles/feet			
Neurologic:	☐ Seizures	☐ Numbness	☐ Tingling	☐ Dizziness	
Constitutional:	☐ Weight gain	☐ Weight loss	☐ Fever	☐ Fatigue	
Gastrointestinal:	☐ Nausea	☐ Vomiting	☐ Jaundice		
Genitourinary:	☐ Frequent urination	☐ Burning urination	☐ Discharge		
Hematologic:	☐ Bleeding	☐ Excessive bruising	☐ Using blood thinners		

Comments: _____

_____

_____

_____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

_____ _____/_____/_____

Signature of patient or legal guardian *Date*