Steven A. Rothstein D.P.M.

First Name:	MI:	Last Name:	Employer/ School:
Home Address:			Work/School Address:
City	State	Zip	City / State / Zip
Home Phone:	Work: / Cell:	SS #:	Occupation: / Employed by Employer: ☐wks ☐mths ☐yrs
Sex: M /F	Age:	Birth Date: / /	Shoe Size: / Marital Status: S M W D / Height: / Weight:

In case of emergency, please first call:	Friend or Relative not living with you:	Please provide your preferred Pharmacy:
Day: Evening: Cell:	Day: Evening: Cell:	Day: Evening: Cell:

Have you been treated for:

☐Ankle Injury	☐Arch Pain	☐Low Back Pain
☐Knee Pain	☐Heel Pain	☐Childhood Foot Problem
☐High Arches	☐Flat Feet	☐Broken Foot Bone(s)
☐Bunions	☐Warts	☐Corns/Callouses
☐Ingrown Nails	☐Neuroma	☐Leg or Foot Ulcers
☐Athlete's Foot	☐Rash	☐Hammertoes
☐Numbness	☐Other	

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

_____

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 when walking:	☐Yes ☐No
Is the pain relieved by rest:	☐Yes ☐No

Do you have or have you ever been treated for:

☐Stroke	☐Heart Attack	☐Hepatitis
☐Phlebitis	☐Osteoporosis	☐Vascular Disease
☐AIDS	☐Glaucoma	☐Rheumatic Fever
☐Cancer	☐Epilepsy	☐Psychiatric Disorder
☐Gout	☐Broken Bone	☐Stomach Ulcer
☐Arthritis	☐Lyme's Disease	☐Keloid/Thick Scar
☐Tuberculosis	☐Nerve Disorder	☐Asthma
☐Scarlet Fever	☐Poor Circulation	☐Lung Disease
☐Diabetes	☐Liver Disease	☐A Heart Condition
☐Anemia	☐Kidney Disease	☐Thyroid

☐Bleeding Disorder ☐High Blood Pressure ☐None of these

Do you have? (please explain below)

Vascular Grafts:	☐Yes ☐No
Joint Implants:	☐Yes ☐No
Replacement Heart Valves:	☐Yes ☐No
Are you now under chemotherapy:	☐Yes ☐No
Have you had any other serious illness:	☐Yes ☐No
Have you ever been hospitalized or been under medical care over 24 hours:	☐Yes ☐No
Have you had any surgery:	☐Yes ☐No
Anything else that you want to tell the doctor:	☐Yes ☐No

Explanations/ Surgeries:

List relationship to you of family members who have had:

Diabetes: _____ Foot Problems: _____
Arthritis: _____ Heart Attack: _____
Stroke: _____ High Blood Pressure: _____
Cancer: _____ Birth Defects: _____

# of childbirths: __ Are you currently pregnant: ☐Yes ☐No
Are you slow to heal after cuts: ☐Yes ☐No
Any abnormal bleeding, bruising or scarring: ☐Yes ☐No
Are you taking insulin: ☐Yes ☐No

Medications:	For What Problem:	For How Long:

Vitamins/ Minerals/ Herbs: _____

Do you smoke now? ☐No ☐Yes Packs/day___Years ___
Did you ever smoke? ☐No ☐Yes Packs/day___Years ___
If you quit, when did you do so? _____
Alcoholic beverages? (circle one)
None Rarely Moderately Daily Quit
Recreational Drugs? (circle one)
None Rarely Moderately Daily Quit

"Allergies": Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

	No	Yes	If yes, what occurs?
Penicillin	☐	☐	
Other antibiotics (list below)	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics (list below)	☐	☐	
Novocaine	☐	☐	
Other anesthetics	☐	☐	
Aspirin	☐	☐	
Empirin, Tylenol	☐	☐	
Advil, Aleve or Motrin	☐	☐	
Other pain remedies (list below)	☐	☐	
Sulfa Drugs	☐	☐	
Adhesive tape	☐	☐	
Shrimp, iodine or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Allergic to/Reaction: _____