Patient # (office use only) _____

CURRENT MEDICATIONS: Please include dosage and number per day ☐ See attached list

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

DRUG ALLERGIES: ☐ Adhesive allergy ☐ Latex allergy

_____

_____

Tobacco History: ☐ None ☐ Chews ☐ Former Smoker ☐ Current Smoker ____ Packs/day

Alchohol History: ☐ None ☐ Previously ☐ Occasionally ☐ Moderate to Heavy

PAST ILLNESS HISTORY:

☐ Angioplasty	☐ Emphysema	☐ Mitral Valve Prolapse
☐ Arthritis	☐ Fibromyalgia	☐ Multiple Sclerosis
☐ Asthma	☐ Gerd Ulcers	☐ Osteoporosis
☐ Bleeding Problems	☐ Gout	☐ Prior Trauma
☐ Blood Disease	☐ Hearing Problems	☐ Psoriasis
☐ Cancer _____	☐ Heart Disease	☐ Resting leg pain
☐ Claudication	☐ Heart Murmur	☐ Rolling in of ankle
☐ Coronary Disease	☐ Hypertension	☐ Rheumatoid Arthritis
☐ Depression	☐ Kidney Disease	☐ Rheumatic Fever
☐ Diabetes/Sugar	☐ Liver Disease	☐ Skin Problems
☐ DVT	☐ Lung Disease	☐ Tetanus shot

☐ Other _____

PAST SURGICAL HISTORY:

☐ Back Surgery	☐ Hand / Wrist	☐ Hip Surgery
☐ Cardiac / Bypass Surgery	☐ Foot / Ankle	☐ Knee Surgery
☐ Do you have any artificial joints? If yes, where? _____		☐ Other _____

I certify that the above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Parent/POA Signature: _____ Date: _____

By signing below, I give my consent to be seen and treated by Dr. Daniel B. DePalma.

By signing below, I authorize Dr. Daniel B. DePalma's practice to bill my insurance for the services provided.

By signing below, I declare that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Parent/POA Signature: _____ Date: _____