Jack Morgan, DPM, FACFAS
Benjamin Scherer, DPM
Miguel A. Rodriguez, DPM
500 N Garfield Ave., Suite 108
Monterey Park, CA 91754
Office (626) 288-2760 Fax (626) 571-6211

New Patient Questionnaire

A. General Information

Name: _____ Age: ____ Height: _____ Weight: _____ SSN#_____-____-_____
Date Of Birth (mm/dd/yyyy)_____/_____/_____ Contact Number: (_____) _____ - _____
Address: _____
Email: _____ Referral Source: _____
Primary Care Provider:_____ Phone:_____ Fax:_____
Pharmacy: _____

B. Medical/Surgical History

Please Check boxes of any past medical problems that you have had:

☐Alcohol Abuse	☐Autoimmune Disorder	☐Asthma	☐Blood Clots(DVT/PE)	☐Coronary Artery Disease
☐Bleeding Disorder	☐Congestive Heart Failure	☐Diabetes	☐Depression	☐COPD/Emphysema
☐Drug Abuse	☐Gastric Reflux/GERD/Ulcer	☐Fibromyalgia	☐Gout	☐Heart Attack
☐Heart Disease	☐High Blood Pressure	☐Hepatitis	☐HIV/AIDS	☐High Cholesterol
☐Kidney Disease	☐Spinal Cord Injury	☐Mental Illness	☐Multiple Sclerosis	☐Obstructive Sleep Apnea
☐Osteoporosis	☐Peripheral Vascular Disease	☐Polio	☐Rheumatoid Arthritis	☐Rheumatic Fever
☐Stroke/TIA	☐Seizure Disorder	☐Liver Disease	☐Thyroid Disease	☐Tuberculosis

☐Cancer – Type: _____ ☐Other: _____

Have you Ever Had Surgery? ☐Yes ☐No Please check boxes of any past surgery that you have had:

☐Wisdom Teeth	☐Appendectomy	☐Carpal Tunnel Release	☐Cataracts	☐Gall Bladder
☐Heart Bypass/stent	☐Hysterectomy	☐Joint Replacement	☐LASIK/PRK	☐Pacemaker/Defibrillator
☐Spine Surgery	☐Tonsillectomy	☐Arthroscopic Surgery-type: _____		

☐Other: _____

Any problems with anesthesia? ☐Yes ☐No Family history of Malignant Hyperthermia? ☐Yes ☐No

Please Describe: _____

C. Current Medication/Supplements (Please list all that you take)

Medication	Dose	Frequency	Medication	Dose	Frequency

D. Allergies

Do you have any known drug allergies? ☐Yes ☐No

☐Penicillin ☐Sulfa ☐Iodine ☐Latex ☐Contrast dye ☐Adhesive tape ☐Other_____

What reaction(s) did you have?_____

Food Allergies?_____

E. Social History

How do you evaluate your general Health? ☐Excellent ☐Good ☐Fair ☐Poor

What is your work status? ☐ Unemployed ☐ Disabled ☐Retired ☐Student ☐Homemaker

What is your occupation? _____

Do you drink Alcohol? ☐Yes ☐No How much?_____

Do you use tobacco products? ☐Yes ☐No

Have you ever used tobacco products? ☐Yes ☐No ☐Cigarettes___packs/day ☐Pipe/Cigar ☐Chewing tobacco

Do you use recreational substances? ☐Yes ☐No Type/Frequency?_____

Do you exercise regularly? ☐Yes ☐No How often? ☐1-2/week ☐3-5/week ☐>5/week

F. Family Medical History (please check boxes of any illnesses that have occurred in blood relatives)

☐Arthritis	☐Auto-Immune disorder	☐Bleeding/Clotting disorder	☐Bone Disease	☐Diabetes
☐Mental Illness	☐Heart Disease	☐Cancer type:_____	☐Rheumatic Arthritis	
☐Thyroid Disease	☐Seizure disorder	☐Other_____	☐NONE	

Mother: Living or Dead_____ Father: Living or Dead_____

Brother: Living or Dead_____ Sister: Living or Dead_____

G. Review of Systems (please check boxes of any symptoms that have occurred in the past 30 days)

Constitutional		**Endocrine**		**Skin**	
Unexpected weight gain/loss	□Yes □No	Excessive thirst	□Yes □No	Skin rash	□Yes □No
Recent fever or chills	□Yes □No	Heat/Cold Intolerance	□Yes □No	Sores or open wounds	□Yes □No
Night Sweats	□Yes □No			Poor healing	□Yes □No
				Abnormal hair loss	□Yes □No
Neurologic		**Gastrointestional**		**Genitourinary**	
Dizziness/Vertigo	□Yes □No	Heartburn	□Yes □No	Blood in urine	□Yes □No
Unsteady gait/Fall(s)	□Yes □No	Change in Appetite	□Yes □No	Painful urination	□Yes □No
Headache	□Yes □No	Nausea	□Yes □No	Flank pain	□Yes □No
Migraine	□Yes □No	Vomiting	□Yes □No	Frequency	□Yes □No
Seizure	□Yes □No	Change in Bowel Habits	□Yes □No	Urgency	□Yes □No
Numbness/tingling	□Yes □No	Bloody/tarry stools	□Yes □No		
Eyes		**Psychiatric**		**Hematologic**	
Visual loss/change	□Yes □No	Anxiety	□Yes □No	Bleeding problems	□Yes □No
Blurred vision	□Yes □No	Depression	□Yes □No	Bruise easily	□Yes □No
Double Vision	□Yes □No	Hallucinations	□Yes □No		
Ear, Nose, Throat		**Cardiovascular**		**Respiratory**	
Hearing loss/changes	□Yes □No	Chest pain	□Yes □No	Short of breath	□Yes □No
Earaches	□Yes □No	Palpitations	□Yes □No	Cough	□Yes □No
Nosebleeds	□Yes □No	Fainting	□Yes □No	Difficulty breathing	□Yes □No
Difficulty Swallowing	□Yes □No	Murmurs	□Yes □No	Inspiration pain	□Yes □No
Active Dental issues	□Yes □No	Leg Swelling	□Yes □No	CPAP/BiPAP use	□Yes □No
Hearing Aids or Denture	□Yes □No			Oxygen use	□Yes □No

I hereby authorize Miguel Rodriguez, DPM; Jack Morgan, DPM and Ben Scherer, DPM to furnish my insurance company all information which said insurance company may request concerning my illness or injury. I hereby assign Miguel Rodriguez, DPM; Jack Morgan, DPM and Ben Scherer, DPM all my payments to which I am entitled for medical/and or surgical expenses relative to the service reported for my illness or injury. I understand that I am financially responsible to said doctor for charges not covered by this assignment for benefits. A photocopy of this assignment is as valid as the original.

Patient Signature: _____ Date: _____