Christianne Transfiguracion, DPM
Christopher Shin, DPM
Joseph Wells, DPM
Susan Scott, DPM
Tho Nguyen, DPM

24640 Jefferson Ave, Suite 109
Murrieta, CA 92562
P: 951-677-1323 F: 951-239-4233

Podiatry Services

☐ Male
☐ Female

Name: ___________________________________ ____________________________________ ____
Last First MI

Phone #:_____________________ ____________________ _____________________ Best number to reach you? ________
Home Work Cell

Address ____ City _____________________________ State ____ Zip ________

Email address ____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth ______________ Age _____ Social Security # _________________________

Primary Care Physician ___________________________________

Employer ____

Spouse Name _______________________________________ Spouse Phone # ____

Emergency Contact _____________________________ Phone # __________________ Relationship _______________________

Pharmacy: _______________________________ Cross Streets and City: ____

What race do you identify with? (check all that apply):
☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other Race ☐ Decline to Disclose

Do you consider yourself Hispanic? ☐ Yes ☐ No ☐ Decline to Disclose

How did you hear about the practice? (circle one)

Internet/Google________________________ Facebook________________________ Friend/Family________________________

Insurance Company_______________ Doctor Referral (who?)_________________________ Other_________________________

Preferred Language: _________________________

INSURANCE INFORMATION
Primary Insurance Company: ____

Secondary Insurance Company: ____

Please specify any family or friends that you authorize our office staff to share your medical information with:

____

--OR-- ☐ I do not authorize the office staff to share my medical information with anyone other than myself.

- I declare that the above information is true and correct and that I have read and understand the information written above. I hereby authorize Drs. Transfiguracion, Shin, Wells, Nguyen and/or Scott to provide medical or emergency care to the above named person or myself. I authorize my insurance company to pay benefits directly to Drs. Transfiguracion, Shin, Wells, Nguyen and/or Scott and also acknowledge that non-covered services are my responsibility.
- I acknowledge that I have read and have received a copy of the Summary of Notice of Privacy Practices and the Patient Financial Policy

Signature ____ Date _______________

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Name: ______________________________ Date ____________

CURRENT PROBLEM: ______________________________

Where? ______________________ For How Long? ______________________

Previous Treatment (x-rays, medication, self-treatment, etc): ______________________

MEDICAL HISTORY

ALLERGIES ☐ **NONE** ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Tape ☐ Latex ☐ Iodine

Other Drug Allergies: ______________________________

CURRENT MEDICATIONS ☐ **NONE** ☐ Aspirin ☐ Coumadin/Warfarin

Other Medications: ______________________________

____

____

ILLNESSES please answer **YES OR NO** if you have had any of the following **OR** are taking medications for the treatment of:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes-how long _____	☐	☐	Atrial Fibrillation	☐	☐	Heart Disease/CAD	☐	☐	Pulmonary Embolus
☐	☐	High Blood Pressure	☐	☐	Autism/Asperger's	☐	☐	Hepatitis A	☐	☐	Raynaud's Disease
☐	☐	Heart Attack-when _____	☐	☐	Back Pain	☐	☐	Hepatitis B	☐	☐	Sciatica
☐	☐	Pacemaker	☐	☐	Blood Clot in Leg (DVT)	☐	☐	Hepatitis C	☐	☐	Sickle Cell
☐	☐	Stroke (CVA)-when_____	☐	☐	Cancer-type_______	☐	☐	High Cholesterol	☐	☐	Slipped Disc/Herniated Disc
☐	☐	Stroke (TIA)-when_____	☐	☐	Cardiac Murmur	☐	☐	HIV/AIDS	☐	☐	Tuberculosis
☐	☐	Allergies, seasonal	☐	☐	COPD	☐	☐	Hyperthyroid	☐	☐	Stomach Ulcer
☐	☐	Alzheimer's	☐	☐	Dementia	☐	☐	Hypothyroid	☐	☐	Varicose Veins
☐	☐	Anemia	☐	☐	Depression	☐	☐	Lupus/SLE	☐	☐	Blind
☐	☐	Angina	☐	☐	Dialysis/Hemodialysis	☐	☐	Multiple Sclerosis	☐	☐	Deaf
☐	☐	Anxiety	☐	☐	Down's Syndrome	☐	☐	Muscular Distrophy	☐	☐	Hearing Aids
☐	☐	Arrhythmia	☐	☐	Emphysema	☐	☐	Neuropathy	☐	☐	Disabled
☐	☐	Arthritis (osteoarthritis)	☐	☐	Epilepsy/Seizures	☐	☐	Osteoporosis	☐	☐	Currently Pregnant
☐	☐	Arthritis (rheumatoid)	☐	☐	Fibromyalgia	☐	☐	Parkinson's	☐	☐	________________
☐	☐	Artificial Heart Valves	☐	☐	GERD/Acid Reflux	☐	☐	Peripheral Arterial or vascular disease			
☐	☐	Asthma	☐	☐	Gout						

MAJOR SURGERIES & HOSPITALIZATIONS

☐ NONE

____

____

____

SOCIAL HISTORY

Occupation ______________________________

Athletic Activities ______________________________

Alcohol ☐ None ☐ Yes- # drinks/week ______________

Tobacco: ☐ Never Smoked ☐ Quit ☐ Yes ___ packs per day

FAMILY HISTORY ☐ **NONE/UNKNOWN** ☐ Heart Attack ☐ Cholesterol ☐ Diabetes ☐ High Blood Pressure ☐ Lupus ☐ Rheumatoid ☐ Stroke ☐ Cancer

REVIEW OF SYMPTOMS Do you currently feel any of the following symptoms? (check all that apply)

☐ **NONE**	☐ Cold feet or toes	☐ Swelling in foot or leg	☐ Fever	☐ Nausea
☐ “Poor Circulation”	☐ Numbness in feet	☐ Calf pain when walking	☐ Vomiting	☐ Chest pain
☐ Spider veins	☐ Burning in feet	☐ Leg cramps at night	☐ Chills	☐ Difficulty Breathing