Louisville Lifestyle MEDICINE

Dr. Angela Didyk, DPM
Podiatry

Name_____Date of Birth _____
Home Address_____
City_____ State_____ Zip_____
Home Phone _____ Work _____ Cell_____
Social Security # _____ E-Mail _____
Marital Status: _____Single _____Married _____Divorced _____Widowed
Employer: _____
Address_____
Primary Care Physician_____
Race: ___Caucasion ___African American ___American Indian ___Other
Language: ___English ___Spanish ___French ___German ___Italian ___Other
Ethnicity: ___Not Hispanic or Latino ___ Hispanic or Latino
How did you hear about Dr.Angela?_____
Whom may we thank for referring us to you? _____
INSURANCE INFORMATION:
Name of Primary Insurance Company_____
Subscriber's name _____Date of Birth_____
Subscriber's SSN _____
Group no. _____Policy no._____
Address and Phone (if different):_____
Subscriber's Employer

_____
Employer address
_____Phone_____
Patient's relationship to subscriber: Self Spouse Child Domestic Partner Other

PODIATRY INFORMATION:
Reason for Visit_____
Duration of Issue? _____days _____months _____years
Severity of pain: (Please circle) 0 1 2 3 4 5 6 7 8 9 10
Prior treatment (stretching, medication, etc)?_____
Height_____Weight_____Shoe Size_____Shoe Type_____

Medications/Dosages:_____
_____
_____
Drug Allergies and reactions:_____
_____
Are you pregnant or do you think you may be pregnant? ____Yes ____No

MEDICAL HISTORY:

ISSUE	Current or Past	Comment
Allergies		
Arthritis		
Asthma/COPD		
Blood Disease		
Cancer (type in comment)		
Diabetes (type in comment)		
Drug/Alcohol Abuse		
Genetic Disease		
Acid Reflux		
Kidney or Liver Disease		
Heart Disease		
Hypertension		
Neurological Disorder		
High Cholesterol		
Anxiety/Depression		
Stroke		
Vascular Disease		
Thyroid Disorder		
Other:		
Other:		
Other:		

SOCIAL HISTORY:

Exercise? Type and frequency?_____

Smoking/Tobacco Use?__Yes_____No_____Amount_____Duration_____

Alcohol Use?____Yes ____No Amount_____ Frequency_____

Illicit Drug Use? ____Yes ____No Amount_____ Frequency_____

Family History (Indicate relative in comment)

ISSUE	Current or Past	Comment
Arthritis		
Asthma/COPD		
Blood Disease		
Cancer (type in comment)		
Diabetes (type in comment)		
Drug/Alcohol Abuse		
Genetic Disease		
Acid Reflux		
Kidney or Liver Disease		
Heart Disease		
Hypertension		
Neurological Disorder		
High Cholesterol		
Anxiety/Depression		
Stroke		
Vascular Disease		
Thyroid Disorder		
Other:		

I certify that the above information is correct to the best of my abilities. I understand that withholding information may be detrimental to my care and my health.

Signature_____ Date_____