

Welcome To Hartsdale Podiatry  
Dr. Mervyn Kaplan, DPM  
80 East Hartsdale Ave., Hartsdale, N.Y. 10530-2810

Please Print

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Circle One: (Mr Miss Mrs Ms) ( Female Male) ( Single Married Divorced Widowed Separated )

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Apt # : \_\_\_\_\_ PH

Telephone #: (914) \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Family Physician : \_\_\_\_\_ Address : \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Medical History (Check One)**

Is there a family history of Diabetes, Heart Disease, Cancer, Bleeding disorders, High Blood Pressure? \_\_\_ Yes \_\_\_ No

Weight : \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ General Health: \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Allergies:	Yes	No		Yes	No		Yes	No
Penicillin	___	___		___	___		___	___
Adhesive Tape	___	___	Foods	___	___	Aspirin	___	___
Rubber	___	___	Anesthetics	___	___	Codeine	___	___

Do you have Diabetes?	___ Yes ___ No	Do you have High Blood Pressure?	___ Yes ___ No
Do you take Blood Thinners?	___ Yes ___ No	Do you take Cortisone?	___ Yes ___ No
Do you have a Pacemaker?	___ Yes ___ No	Are you pregnant or nursing ?	___ Yes ___ No
Do you use alcohol?	___ Yes ___ No	Do you smoke?	___ Yes ___ No
Do you bleed easily?	___ Yes ___ No	Do you take medication?	___ Yes ___ No

Do you use any of the following: special shoes, cane, walker, wheel chair? \_\_\_ Yes \_\_\_ No

List the Medication you are taking:

**Have you had any of the following medical complaints?**

Arthritis	___ Yes ___ No	Hepatitis	___ Yes ___ No	Heart Disease	___ Yes ___ No
Ulcers	___ Yes ___ No	Cancer	___ Yes ___ No	Epilepsy	___ Yes ___ No
Tuberculosis	___ Yes ___ No	Venereal Disease	___ Yes ___ No	Cataracts	___ Yes ___ No
Glaucoma	___ Yes ___ No	Asthma	___ Yes ___ No	Kidney Disease	___ Yes ___ No
Anemia	___ Yes ___ No	Blood Transfusion	___ Yes ___ No	Rheumatic Fever	___ Yes ___ No
Foot Surgery	___ Yes ___ No	Broken Bones	___ Yes ___ No	Previous Foot Care	___ Yes ___ No
Nail Surgery	___ Yes ___ No	Knee Pain	___ Yes ___ No	Hip Pain	___ Yes ___ No
Back Pain	___ Yes ___ No	Varicose Veins	___ Yes ___ No	Joint Stiffness	___ Yes ___ No
Numbness	___ Yes ___ No	Hearing Problems	___ Yes ___ No		
Hiatus Hernia	___ Yes ___ No				

Do you have medical insurance?: \_\_\_ Yes \_\_\_ No

Signature: \_\_\_\_\_