Conway Podiatry Center, P.C.
8020 Myrtle Trace Drive
Conway, SC 29526
Health Information Sheet

Patient Name _____
First Initial Last
Patient Address_____
Street City State Zip
Telephone #_____work#_____
Social Security# _____
Date of Birth___/___/___ Age_____ Sex _____ Marital Status_____
Name of Ins. card holder if other than self: _____
Social Security # of Ins.Holder:_____ d/b_____/_____/_____
How did you hear about our practice? Friend___Family___Yellow Pages___
Newspaper ____ Other explain _____
Doctor Referral ____ Dr. Name _____
Who is your family Physician? _____

Please list any allergies you have to medications (such as Novocain or Penicillin) _____
Do you smoke _____
Do you consume alcohol _____

Have you ever been treated for?
___Diabetes
___Heart disease
___Stroke
___High blood pressure
___Arthritis
___Rheumatic fever
___Kidney disease
___Liver disease

Do you experience?
___Bleeding problems
___Leg cramps
___Arch pain
___Numbness in feet
___Tingling in feet
___Back pain
___Leg weakness

Please explain reason for this visit _____
_____

Please list any serious illnesses and operations_____
_____

Please list ALL medications _____
_____