ISLAND
FOOT & ANKLE

Bruce McLaughlin, DPM
Edward McLaughlin, DPM
Anthony Ferraro, DPM
John Kannengieser, DPM
Alexandra LaRocca, DPM

Patient Update Form

Date: ___ /___ /_____

Patient Name: ______________________ ______________ ____ Date of Birth: ___ /___ /_____ Age: ___ Sex: M F
Last First MI

Home Address:____ City: ______________ State: _____ Zip: _________

Home Phone: (____) ______ -________ Cell Phone: (____) ______ -________ Social Security #: ______-______-_______

Email: ____

Occupation: ____________________________ Referred to practice by: ____

Primary Care Physician: ______________________ PCP Address: ____

Emergency Contact: __________________________ Relationship: ________________ Phone: (____) ______ -_________

Pharmacy: __________________ Address:_____________________ City: ______________ State: _____ Zip: _________

What specific problem brought you to the office today?

____

____

Allergies to food or medication (please add what type of reaction you have, eg: rash, trouble breathing):

□ Penicillin □ Novacaine (local anesthetic) □ Cortisone □ Sulfa Drugs □ Iodine □ NSAIDS (anti-inflammatory) □ Tape
□ Latex □ Opiates (codeine, oxycontin etc.) □ Antibiotics (specify) □ Other____

Medical Problems (circle all that apply, list any other issues):

Diabetes type I	Bleeding Disorder	Stroke	Hypertension
Diabetes type II, no insulin	Joint replacement	Chronic Bronchitis	Heart Disease
Diabetes type II, insulin	Gout	Emphysema	Mitral Valve Prolapse
Peripheral Neuropathy	Fibromyalgia	HIV +	Other: ______________
Chronic Ulcer of Skin	Cancer _______________	Heptatitis B / C	____________________
Peripheral Vascular Disease	Organ Transplant ______		____________________

Other pertinent health history: ____

____

Family History: ____

Surgical History: ____

Marital Status: ____________ Alcohol Use: ______________ Smoking: (current or former) ___________ ___ pk/day

Current Medications (name, dose, frequency):____

____

If Patient is a Minor: Fathers name: _________________________ Mothers Name: __________________________

Parental Signature: __________________________ Print Name: __________________________ Date: ___ /___ /_____

• 1111 Montauk Highway Ste 100 West Islip, NY 11795 • Tel: (631) 422-4450 • Fax: (631) 422-4451
• 952 Roanoke Avenue Riverhead, NY 11901 • Tel: (631) 727-3592 • Fax: (631) 727-8892
• 193 Broadway Amityville, NY 11701 • Tel: (631) 264-1910 • Fax: (631) 264-1926
www.IslandFootAndAnkle.com