LOUISE E. TORTORA, D.P.M

FAIRFIELD, CT 06824

PATIENT INFORMATION

NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____________________ CITY __________ STATE ______ ZIP__________

HOME PHONE: ______________ WORK: ______________ CELL: ______________

DATE OF BIRTH: __________ AGE: ______ SOCIAL SECURITY: ______________ SEX: __________

RACE: Asian Black Caucasian Native American Pacific Islands Other

ETHNICITY: Hispanic / Non-Hispanic LANGUAGE: ______________

MARITAL STATUS: Single Married Divorced Widowed Other

E-MAIL: ______________________________

PRIMARY CARE PHYSICIAN: ____________________ PHONE: ______________

INSURANCE INFORMATION

INSURANCE: ______________________ POLICY #______________________

POLICY HOLDER: ____________________ DOB: __________ RELATIONSHIP: __________

IN CASE OF EMERGENCY, PLEASE LIST A RELATIVE OR FRIEND (PREFERABLY NOT LIVING WITH YOU)

NAME: ____________________ RELATIONSHIP: __________ PHONE: ______________

AUTHORIZATION TO RELEASE INFORMATION

The release of information acquired in the course of my examination is hereby given.

Signature: ________________________________ Date: ______________

MEDICAL HISTORY

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

- ☐ ALCOHOL PROBLEMS
- ☐ ANEMIA, EASY BLEEDING, BLOOD DISORDERS
- ☐ CHEST OR LUNG PROBLEMS
- ☐ DIABETES
- ☐ DISFIGURING SCARS OR KELOIDS
- ☐ HEART PROBLEMS OR HIGH BLOOD PRESSURE
- ☐ HEPATITIS
- ☐ HIV TEST POSITIVE
- ☐ GENTIAL OR URINARY PROBLEMS
- ☐ GLAUCOMA OR OTHER EYE PROBLEMS
- ☐ PSYCHIATRIC OR NEUROLOGICAL ILLNESS
- ☐ SKIN PROBLEMS
- ☐ SINUS, NOSE OR THROAT PROBLEMS
- ☐ STOMACH OR BOWEL PROBLEMS
- ☐ SUBSTANCE ABUSE
- ☐ TOBACCO

DO YOU HAVE A PACEMAKER? ______________________________

DO YOU BLEED EASILY? ______________________________

ALLERGIES:

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CURRENT MEDICATIONS:

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PHARMACY: ______________________ PHONE: ______________

PREVIOUS OPERATIONS:

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DO ANY DISEASES RUN IN YOUR FAMILY?

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REASON FOR SEEING DOCTOR:

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