

**Jennifer Sartori, DPM, PLLC**

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**PLEASE COMPLETE ALL SECTIONS OF THIS PAGE**

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

Name: (Last,First,Middle) \_\_\_\_\_

Street: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: **M** or **F** Primary Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital status: **S M D** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse: \_\_\_\_\_ Emergency contact & phone #: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Office Phone # (\_\_\_\_) \_\_\_\_\_

If minor: Parent/Guardian: \_\_\_\_\_

How did you find out about us?  Family doctor  Newspaper / Name of paper: \_\_\_\_\_  
 Friend  Family  Our website  Insurance website  Other: \_\_\_\_\_

**List medications you are currently taking (including non-prescription and vitamins)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**List allergies & reaction:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**List Surgeries:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Circle below any or all that pertain to your medical history:**

Ulcers	Sickle cell
Kidney	Transfusions
Liver	Circulation
Lungs	Cancer
Thyroid	Seizures
Communicable diseases	Stroke
Heart	Fainting
Gout	Hepatitis
Phlebitis	Anemia
Diabetes	Substance abuse
High blood pressure	Bleeding
Stomach	Arthritis
Intestine	Depression
Urinary	Social alcohol use
Asthma	Rheumatic fever
TB	

Current Tobacco use: **Yes** or **No** (circle one) Past Tobacco use **Yes** or **No** (circle one)

Pregnant: **Yes** or **No** (circle one) Nursing: **Yes** or **No** (circle one)

Other pertinent medical conditions: \_\_\_\_\_

Pertinent family medical history: \_\_\_\_\_

**I am here today for: (Please circle all that apply)**

- |                                  |                            |                               |
|----------------------------------|----------------------------|-------------------------------|
| 1. Abnormal shoe wear            | 10. Hammertoes             | 18. Running/sports injury     |
| 2. Ankle fracture or injury      | 11. Heel pain              | 19. Second opinion            |
| 3. Arthritis                     | 12. Knee or back pain      | 20. Shin splints / tendonitis |
| 4. Biomechanical/gait evaluation | 13. Nail problem           | 21. Skin problem              |
| 5. Bunion                        | 14. Nerve pain             | 22. Sprain of ankle / foot    |
| 6. Deformed joints               | 15. Pain / fatigue in feet | 23. Surgery evaluation        |
| 7. Diabetes check                | 16. Poor circulation       | 24. Toe fracture / injury     |
| 8. Evaluation of child's feet    | 17. Prescription orthotics | 25. Other _____               |
| 9. Foot fracture or injury       |                            |                               |