PAUL S. PEICOTT, DPM
• FELLOW, ACFAS
• DIPLOMATE, ABPM

MATTHEW V. CAPOZZI, DPM
• FELLOW, ACFAS
• DIPLOMATE, AAWM

QUINN T. CHARBONNEAU, DPM
• ASSOCIATE, ACFAS
• DIPLOMATE, ABPM

DANIEL E. BROWN, DPM
• DIPLOMATE, ABPM

DANIEL R. MARCUS, DPM
• DIPLOMATE, ABPM
• DIPLOMATE, ABMSP

PEABODY PODIATRY
Podiatrists - Foot Surgeons

NAME_____ CITY _____
ADDRESS_____STATE/ZIP_____
PHONE #_____DATE OF BIRTH_____

PRIMARY CARE PHYSICIAN_____
ADDRESS_____

PHARMACY NAME AND LOCATION_____

HOW WERE YOU REFERRED TO THIS OFFICE?_____

PLEASE CIRCLE ALL OF YOUR MEDICAL PROBLEMS AND ADD ANY NOT LISTED BELOW:

AIDS
ANEMIA
ANXIETY
ARTHRITIS
ASTHMA
BLOOD CLOTS
CANCER
DEPRESSION
DIABETES
IF YES, HOW LONG?
GOUT
HEART DISEASE
HEART MURMUR
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HIV POSITIVE
KIDNEY DISEASE
LUNG DISEASE
NEUROPATHY
PHLEBITIS
COUMADIN THERAPY
VENEREAL DISEASE
SEIZURES
SKIN CANCER
STROKE
THYROID DISORDER
TUBERCULOSIS
ULCERS (SKIN)
ULCERS (STOMACH)
VARICOSE VEINS
POOR CIRCULATION

OTHER_____

"I request that payment of authorized Medicare or any other insurance benefits to be made on my behalf to Dr. Paul Peicott, Dr. Matthew Capozzi, Dr. Quinn Charbonneau, Dr. Daniel Brown or Dr. Daniel Marcus for any services furnished to me by the provider. I authorize any holder of medical information about myself to release to the Health Care Finance Administration, or its agents, any information needed to determine benefits for related services."

HMO PATIENTS: I am aware that I will be responsible for payment of services if I did not obtain a referral for today's visit.

SIGNATURE_____ DATE_____

Please list the **names and doses of ALL** medications/vitamins/supplements you are currently taking:

_____

_____

_____

_____

Please list allergies you have to **ANY** medications, metal, latex, adhesive tape, etc.:

_____ Type of reaction: _____

SMOKING STATUS (check one box)

Current smoker _____ Former smoker _____ Never smoked _____

SOCIAL STATUS

Do you drink alcohol? _____ If yes, how often? _____ If you quit, how long ago? _____

Do you use illicit drugs? _____ If yes, what and how often? _____ If you quit, how long ago? _____

Do you have a walking/exercising routine? _____ How many times per week? _____

What is your occupation? _____

FAMILY HISTORY _____ Adopted

Does/did anyone in your family have any of the following? If yes, please describe who.

Diabetes _____ Heart Disease _____

Cancer (type) _____ Stroke/Blood Clots _____

SURGICAL HISTORY

Please list **ALL** past **surgical procedures**:

_____

_____

_____

REVIEW OF SYSTEMS: CIRCLE if you are experiencing any of these problems **TODAY:**

HEENT
Headaches
Vision Problems
Dizziness
Ringing in Ears
Nose Bleeds
Difficulty Swallowing

CARDIOVASCULAR
Chest Pain
Heart Failure

RESPIRATORY
Shortness of Breath
Pneumonia

GASTROINTESTINAL
Acid Reflux
Stomach Ulcers

GENITOURINARY
Bladder Problems
Kidney Problems

HEMATOLOGIC/LYMPH
Blood Disorder
Lymph Node Disorder

MUSCULOSKELETAL
Joint Pain
Muscle Pain

ALLERGIC/IMMUNOLOGIC
Seasonal Allergies
Autoimmune Disorders

NEUROLOGICAL
Neuromuscular Problems
Neuropathy

INTEGUMENTARY
Melanoma
Eczema

****WHAT PROBLEM ARE YOU HAVING WITH YOUR FEET TODAY THAT BRINGS YOU TO THE OFFICE?****

_____

_____

_____