# Dr. Zina B. Cappiello DPM, LLC

## Medical Intake Form

**Patient Name**: _____**Date of Birth:** _____ **Today's Date:** _____

**Reason for today's visit:** _____

**Height** _____ **Weight** _____ **Shoe Size** _____

**Primary Care Physician:** _____

**Pharmacy Name, Location, Number:** _____

**Allergies to medication:** _____

**Current medications:** _____

_____

_____

**Past Medical History, Medical Conditions** *(High Blood Pressure, Cholesterol, Heart Disease, Diabetes, Liver Disease, Kidney Disease, Hepatitis, HIV, Thyroid disorder, any other medical conditions)***:**

_____

_____

_____

If you are Diabetic: (circle) Type I Type II How Long have you been Diabetic _____

Do you take Insulin? _____

**Past Surgical History:** _____

**Family Medical History** ***(Cancer, Heart Disease, Diabetes or other medical conditions )*****:**

**Father:** _____

**Mother:** _____

**Current Smoker** (circle): Yes No **Former Smoker (circle):** Yes No

**Do you drink alcohol** (circle): Never Occasionally Daily

**Emergency Contact Name:**_____ **Number:**_____

**Patient Signature:** _____