DR. GREG D. POUND D.P.M PA FACFAS
WOUND CARE SPECIALISTS OF SW FL.
BOARD CERTIFIED AMERICAN BOARD OF FOOT AND ANKLE SURGERY
BOARD CERTIFIED LIMB PRESERVATION AND SALVAGE
17595 S TAMIAMI TRAIL S FORT MYERS FL. 33908

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: ______________ ______________ _____ AGE: _____ SEX: M F
LAST FIRST M

DATE OF BIRTH: _______/_______/_______ AGE: _______ SOCIAL SECURITY #: ______________________

HOME ADDRESS: ______________________ CITY/STATE: ______________ ZIP: _________
OTHER ADDRESS ______________________ CITY/STATE: ______________ ZIP: _________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ______-________ YES NO

WORK PHONE #: (___) ______-________ YES NO

CELL PHONE #: (___) ______-________ YES NO

E-MAIL: ______________________________ YES NO

PRIMARY LANGUAGE: ______________

RACE: ______________________ ETHNICITY: ______________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: ______________ RELATIONSHIP: __________ PHONE #: (____) ______-______

EMERGENCY CONTACT: ______________ **RELATIONSHIP:** __________ PHONE #: (___) _____-______

PRIMARY CARE DOCTOR: ______________________ PHONE: ______________________

PHARMACY: ______________ LOCATION: ______________ PHONE #: (_____) ______-______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION WITH?
_____ YES NAME(S) ____
_____ NO

WHO REFERRED YOU TO US? ____

EMPLOYER: ______________________ OCCUPATION: ______________________

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ______ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ______ TYPE ______________

ARE YOU PREGNANT ☐ YES ☐ NO ARE YOU NURSING ☐ YES ☐ NO