Katherine E. Chou, DPM

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Last Name:	First Name:	Middle Initial:
Do you have a different/pre	eferred first name? (Nickname, Chosen name, etc.):	
DOB (required):	What is your sex? Male Female	
Marital Status: Sing	ngle Married Significant Other Widowed	
Ethnic Group (Select On	ne): Race: (Select all that apply)	
Latino/Latina/Hispa	anic 🔄 American Indian 🔄 Nati	ve Hawaiian
Non-Hispanic or La	atino/a 🛛 🗌 Alaskan Native 🔄 Paci	fic Islander
 Declined/Unknowr	n Asian Othe	er/Unknown/Declined
── White ── White Address:	Black/African American Whi City:	e State: Zip Code:
Employment Status (Cho	eck one): Full Time Part Time Retired	Self-Employed
Occupation:		
Employer:		
Primary		
Language:		
CON		
SSN:		
	<i>nent reminders will be sent to 1st number listed.</i> Confidential Me	ssage OK? □Yes □No
one Number: Appointme		ssage OK? □Yes □No
Cell Home Work:	Confidential Me	ssage OK? □Yes □No
Cell Home Work: Cell Home Work: Email address:	Confidential Me	
Cell Home Work:	Confidential Me	ssage OK? Yes No
Cell Home Work: Email address:	Confidential Me	Other:
Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP	Confidential Me	Other:
Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit	Confidential Me Confidential M	Other:
Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit	Confidential Me	Other: italizations: C-Section Foot Surgery Valve Replacement
Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit High Blood Pressure Scoliosis	Confidential Me	Other: italizations: C-Section Foot Surgery
Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit High Blood Pressure Scoliosis Asthma	Confidential Me	Other: italizations: C-Section Foot Surgery Valve Replacement
Dee Number: Appointme Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit High Blood Pressure Scoliosis Asthma High Cholesterol	Confidential Me	Other: italizations: C-Section Foot Surgery Valve Replacement
Dee Number: Appointme Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit High Blood Pressure Scoliosis Asthma High Cholesterol Kidney Disease	Confidential Me	Other: italizations: C-Section Foot Surgery Valve Replacement
Dee Number: Appointme Cell Home Work: Email address: Primary Care Provider (PCP): Referral Source: PCP Medical Condit High Blood Pressure Scoliosis Asthma High Cholesterol Kidney Disease Thyroid Disease	Confidential Me	Other: italizations: C-Section Foot Surgery Valve Replacement

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Family History:
Do you have a family history of any of the following?
Key: M-mother F-father, Si-sister, B-brother, D-daughter, So-
Son
Diabetes: M F Si B D So High Blood Pressure: M F Si B D So
Heart Attack: M F Si B D So Stroke: M F Si B D So
High Cholesterol: M F Si B D So Cancer, type: M F Si B D So
Social History:
Please answer the following questions regarding your social history
Tobacco Use: Never Smoker Former Smoker
Current Smoker Packs/Day: Years:
Do you drink alcohol? Yes No
If Yes, how many of the following do you have per week? Drinks/Week:
Do you currently use any recreational drugs?
Marijuana: Medicinal? Recreational? Cocaine
Allergies:
Do you have a severe allergy to any of the following? (Please select all that apply)
Sulfa Penicillin Aspirin Codeine Latex Adhesive tape Medication:
Medications:

Niedications:

List all medications, vitamins, or other supplements you are taking.

Name of Medication	Strength/Frequency	

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-	This is the	most imp	ortant part	of this paper work	
In the last few	month has there	e been a rece	nt change in you	ır:	
Weight	Work	Activity	Shoe Gear	Flooring at work or home	
Please explain:					
Please tell us v	what your Goal a	and Expectat	ion are relating t	to your problem:	
Relating to your					
specific					
complaint(s), what would you					
like to					
accomplish					
during your visit today?					
	nosific complaint				
(s), what would ye	pecific complaint ou like to be able				
to accomplish in t	the near future				
	be able to do right				
at this moment? (intermediate and	•				
		C	OFFICE POLICIES		
-				olicy and I have read and understar nancial Policy and I have read and	nd the
	e notice. I agree				

Signature of patient
(or financially responsible party)
*The typed name is acceptable as an electronic signature

Relationship

Date