

**Patient Information Update Form:**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name\_\_\_\_\_Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: (Home)\_\_\_\_\_ (Mobile)\_\_\_\_\_

Address: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Date Last Seen by PCP:\_\_\_\_/\_\_\_\_/\_\_\_\_

**Have you had a Flu shot from 08/01/25 – 03/31/26 (Please Circle) Yes No**

Email:\_\_\_\_\_

Pharmacy:\_\_\_\_\_ Phone:\_\_\_\_\_

**Medical History:** Circle only those conditions that apply.

If none apply to you, circle: None Apply.

Anemia / Blood Disease or Disorder

Anxiety/Depression

Arthritis / Rheumatoid / Osteoarthritis

Artificial heart valves/Artificial joints

Asthma / Emphysema / Lung problems

Autoimmune Disease/HIV/AIDS

Back problems/Herniated Discs/Stenosis

Blood Clots

Broken Bones in Feet / Legs

Cancer (Type): \_\_\_\_\_

Charcot Joint

Chronic Diarrhea

Circulation Problems/Varicose Veins

CVA (Stroke) / TIAs

Diabetes: Diet/Oral/Insulin \_\_\_\_#yrs

DVT/Phlebitis

Epilepsy/Fainting/Seizures

Eye Pathology

If Over 65-History of Falls: Yes No

Fibromyalgia

Gastric Reflux/Hiatal Hernia

GI Ulcers/Stomach Problems

Gout

Heart Disease/ Angina/Chest Pain

High Blood Pressure

High Cholesterol

Hypothyroidism/Thyroid Problems

Kidney disease/Problems

Leg cramps/Numbness

Liver disease/Hepatitis/Jaundice

Lupus

Multiple Sclerosis

Neuropathy

Peripheral Vascular Disease

Rheumatic Fever

Skin problems/Psoriasis

Weight Change: Loss/Gain

Other Medical Problems (please list):

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Surgical History:** (Circle only those items that apply)

Foot Surgery: Type: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ RT/LT (Please Circle)

Angioplasty of the _____	Cataract	Kidney Stone
Appendectomy	D&C	Mastectomy
Arterial Bypass of the _____	Gall Bladder	Open Heart
Back Surgery	Heart Surgery	Pacemaker
Breast Biopsy/Lumpectomy	Hip/Knee Replacement	Prostate
Caesarean Section	Hysterectomy	Tonsillectomy
Carotid Artery	Kidney Removal	Venous Ligation

Other Surgical History: (Please List)

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**Social History:** (Circle only those items that apply)

Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_ # of Packs Per Day  
 Caffeine (Coffee / Tea / Soda) \_\_\_\_\_ # Cups / Cans / Bottles Per Day  
 Recreational Drugs \_\_\_\_\_  
 Activities (Sports/Exercise) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**Medications:** (Please list both prescription and non-prescription medications & supplements)

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**Allergies:** (Please Circle)

No Known Drug Allergies

Adhesive Tape	Motrin/Advil
Aspirin	Neosporin
Codeine	Novocain
Cortisone	Penicillin
Iodine	Sulfa
Latex	Other: _____

\*\*\*\*\*FOR MEDICAL STAFF ONLY\*\*\*\*\*

BP: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_

Initials \_\_\_\_\_

# **WESTSIDE PODIATRY CENTER, LLP**

**JAMES W. FARRELL, D.P.M.**                      **CHAD R. ROUNDS, D.P.M.**  
**DANIEL T. SMITH, D.P.M.**                      **EDWARD L. WADIE, D.P.M.**  
**KAREN A. STANLEY, D.P.M.**    **JUSTIN C. BEABES, D.P.M.**    **ADAM T. BERSANI, D.P.M.**

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## **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.**

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Parent or Authorized Representative (if applicable)**

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## **AUTHORIZATION TO RELEASE INFORMATION**

I authorize the following individuals to have access to my "Protected Health Information."

**Please list names:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I give permission for Westside Podiatry, when leaving messages, to identify that you are calling from Westside Podiatry.

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**This form expires one year from the date of signature.**

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5104 W. Genesee Street  
Camillus, NY 13031  
(315) 701-3348

27 Fennell Street  
Skaneateles, NY 13152  
(315) 685-3338

7458 Oswego Road  
Liverpool, NY 13090-1500  
(315) 546-0285

130 East 2<sup>nd</sup> Street  
Oswego, NY 13126  
(315) 532-6600

6253 State Rte. 31  
Cicero, NY 13039  
(315) 516-8193