

Practice: Family Foot Health Center, PC

Today's Date: _____

Name: _____ DOB: _____ Chart Number: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other

Phone #: _____ Sex: Male Female DOB: ____/____/____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self Other

Phone #: _____ Sex: Male Female DOB: ____/____/____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend

Other: _____

What is the reason for your visit today? _____

Result of accident or work injury? Yes No

How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ____/10

The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

History and Physical

Name: DOB: Chart Number:

Medical History:

<input type="checkbox"/> Liver	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Neuropathy (specify) <input type="text"/>	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Arthritis (specify) <input type="text"/>	<input type="checkbox"/> Thyroid disease (specify) <input type="text"/>	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA	
<input type="checkbox"/> other (specify) <input type="text"/>	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Stroke			

Are you pregnant? Yes No **Are you nursing?** Yes No

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe:

Do you have any artificial joints? Yes (where?) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long?

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify:

Yes, I had a past substance abuse problem. Please specify:

No, I have never had a substance abuse problem

What is your occupation? Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise:

Family History Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's	<input type="text"/>	<input type="checkbox"/> Depression	<input type="text"/>
<input type="checkbox"/> Arthritis	<input type="text"/>	<input type="checkbox"/> Diabetes	<input type="text"/>
<input type="checkbox"/> Bleeding disorders	<input type="text"/>	<input type="checkbox"/> Emphysema	<input type="text"/>
<input type="checkbox"/> Blood clot	<input type="text"/>	<input type="checkbox"/> Heart disease	<input type="text"/>
<input type="checkbox"/> Cancer	<input type="text"/>	<input type="checkbox"/> High Blood Pressure	<input type="text"/>
<input type="checkbox"/> Cataracts	<input type="text"/>	<input type="checkbox"/> Neurological	<input type="text"/>
<input type="checkbox"/> Circulation problems	<input type="text"/>	<input type="checkbox"/> Strokes	<input type="text"/>
<input type="checkbox"/> Other (specify):	<input type="text"/>		

Review of Systems (Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency	
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> constipation
Integumentary	<input type="checkbox"/> athlete's foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
					<input type="checkbox"/> NONE
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders
					<input type="checkbox"/> NONE
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis
					<input type="checkbox"/> NONE
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:

Date:

Name: **Chart #:** **Date of birth:**

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander Declined to specify

Preferred Language: Declined to specify

Pharmacy Name: **Pharmacy Phone:**

Pharmacy Address: City, State, Zip:

Primary Care Physician: Phone: Date Last Seen:

Address:

Referring Physician: Phone: Date Last Seen:

Address:

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address:

Who can we leave messages with? Wife Husband Daughter Son Other:

Name(s):

Smoking Status

Current Every Day Smoker, Current Status Unknown
 Current Some Day Heavy Tobacco Unknown If Ever
 Former Never Light Tobacco I decline to answer

Vital Signs

Blood Pressure: /

Height: Weight:

Current Medications

No Known Medications I take the following medications:

Name / Dose:

Name / Dose:

Name / Dose:

Name / Dose:

Name / Dose:

Name / Dose:

Name / Dose:

Name / Dose:

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: Reaction:

Name: Reaction:

Name: Reaction:

Name: Reaction:

Name: Reaction:

Name: Reaction:

Name: Reaction:

Name: Reaction:

Last Flu Shot Date: **Did you get a pneumococcal vaccination?** Yes No

Have you fallen in the last 12 months? Yes No **Were you injured from the fall?** Yes No

Advanced Directives: Living Will DNR Durable Power of Attorney Surrogate Appointed None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: Date: