FOOT & ANKLE CENTERS

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___ **AGE:** ___ **SEX:** ☐ M ☐ F
LAST FIRST MI MM DD YYYY

HOME ADDRESS: _____ SS# _____
STREET CITY STATE ZIP

PHONE #: HOME (____) ____-_____ WORK (____) ____-_____ CELL (____) ____-_____

E-MAIL: _____

PRIMARY CARE DOCTOR: _____ PHONE #: (___) ____-_____ LAST SEEN: _____

PHARMACY: _____ LOCATION _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: (____) ____-_____
IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
☐ YES ☐ IF YES, NAME: _____ RELATIONSHIP _____ PHONE #: (____) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ PHONE #: (____) ____-_____
STREET CITY STATE ZIP

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ PHONE #: (____) ____-_____
STREET CITY STATE ZIP

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ POLICY # _____ GROUP # _____

ALLERGIES

☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE
☐ MEDICATIONS _____ ☐ ANESTHESIA _____
☐OTHER_____ ☐ NONE KNOWN

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER AND HERBAL SUPPLEMENTS):

_____ _____ _____
_____ _____ _____
_____ _____ _____

PATIENT NAME: _____

MEDICAL HISTORY

PLEASE CHECK THE BOX IF YOU CURRENTLY OR IN THE PAST HAVE HAD THE FOLLOWING SYMPTOMS:

ARTHRITIS:	☐ RHEUMATOID ☐ OSTEO ☐ GOUT ☐ OTHER
EENT:	☐ TONSILLITIS ☐ GLAUCOMA ☐ CATARACTS ☐ EYE /VISION DIS. ☐ HEADACHES ☐ MIGRAINES ☐ HEARING DEFICIT
GASTROINTESTINAL:	☐ ULCERS ☐ REFLUX ☐ HERNIA ☐ BOWEL DIS. ☐ IRRITABLE BOWEL SYN. ☐ HEMORRHOIDS ☐ GI BLEEDING
GENITO-URINARY:	☐ KIDNEY OR BLADDER INFECTIONS ☐ KIDNEY STONES ☐ PROSTATE DISORDER ☐ STD
MAJOR ILLNESSES:	☐ DIABETES TYPE I /TYPE II ☐ HYPERCHOLESTROLEMIA ☐ HYPERTENSION ☐ CHEST PAIN ☐ MI ☐ CANCER ☐ MITRAL VALVE PROLAPSE ☐ HEART MURMUR ☐ ARRHYTHMIA ☐ STROKE ☐ CHF ☐ PACEMAKER ☐ HEART DISEASE
PSYCHOLOGICAL:	☐ ANXIETY ☐ DEPRESSION ☐ PSYCHIATRIC CONDITION ☐ DRUG OR ALCOHOL DEPENDENCY
RESPIRATORY:	☐ ASTHMA ☐ TUBERCULOSIS ☐ EMPHYSEMA ☐ SINUS PROBLEMS ☐ SHORTNESS OF BREATH ☐ COPD ☐ LUNG DISEASE
SKIN DISORDERS:	☐ PSORIASIS ☐ SKIN CANCER
VASCULAR DISEASE/BLOOD DISORDERS:	☐ POOR CIRCULATION ☐ SICKLE CELL ☐ PERIPHERAL VASCULAR DISEASE ☐ LEG OR CALF PAIN ☐ NIGHT CRAMPS ☐ REST PAIN ☐ VEIN PROBLEMS ☐ SWELLING ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ LEG ULCERS ☐ BLOOD CLOT ☐ DVT ☐ PE ☐ ANEMIA ☐ BLEEDING OR CLOTTING DISORDERS ☐ EASY BRUISING ☐ TRANSFUSIONS
OTHER ILLNESSES:	☐ EPILEPSY OR SEIZURES ☐ THYROID DISEASE ☐ MUSCLE DISEASE ☐ HEPATITIS ☐ HIV OR AIDS ☐ LYME DISEASE ☐ OTHER: _____
OTHERS:	**ARE YOU PREGNANT?** ☐ YES ☐ NO **ARE YOU NURSING?** ☐ YES ☐ NO **HEIGHT:** _____ **WEIGHT:** _____

SURGICAL HISTORY

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ 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 _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

PATIENT NAME: _____

FAMILY HISTORY

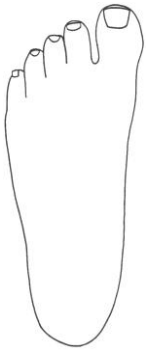
DO YOU HAVE A FAMILY HISTORY OF:	☐ DIABETES: TYPE 1 OR TYPE 2	☐ CANCER
☐ THYROID DISEASE	☐ HIGH BLOOD PRESSURE	☐STROKE
☐ CORONARY ARTERY DISEASE	☐ RHEUMATOID ARTHRITIS	☐ OTHER _____

CURRENT PROBLEM

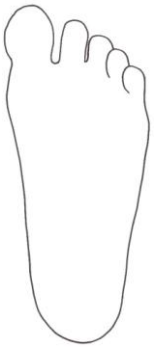
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

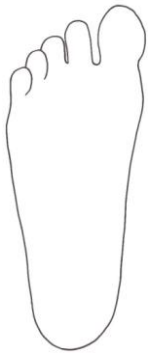


BOTTOM OF FOOT

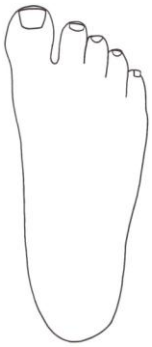
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PLEASE READ THE ACKNOWLEDGEMENT ON THE NEXT PAGE AND SIGN IT. THANK YOU.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE