Foot And Ankle Health Group

WELCOME TO FOOT AND ANKLE HEALTH GROUP, P.C. PATIENT # _____

PATIENT FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE OF BIRTH_____ AGE_____ SOCIAL SECURITY # _____

SEX: MALE_____ FEMALE_____ YOUR MARITAL STATUS: SINGLE _____ MARRIED _____ WIDOWED_____ SEPARATED_____ DIVORCED_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ EMAIL _____

WHOM MAY WE THANK FOR REFERRING YOU_____ ADDRESS_____

NAME AND PHONE OF EMERGENCY CONTACT PERSON_____

INSURANCE CO. NAME_____ ID # _____ GROUP # _____

NAME OF INSURED & DATE OF BIRTH FOR ACCT. _____ RELATIONSHIP_____

ADDITIONAL INSURANCE _____ ID # _____ GROUP#_____

DO YOU HAVE ANY OF THE FOLLOWING :

	YES	NO		YES	NO		YES	NO
AIDS / HIV	___	___	CIRCULATORY PROBLEMS	___	___	PHLEBITIS	___	___
ANEMIA	___	___	DIABETES I OR II	___	___	PRONE TO INFECTION	___	___
ARTHRITIS	___	___	EPILEPSY	___	___	RHEUMATIC FEVER	___	___
ASTHMA	___	___	FAINTING SPELLS	___	___	SHORTNESS OF BREATH	___	___
BACK PROBLEMS	___	___	HEART DISEASE	___	___	STOMACH ULCERS	___	___
BLOOD DISORDERS	___	___	HIGH BLOOD PRESSURE	___	___	STROKE	___	___
CANCER	___	___	KIDNEY DISEASE	___	___	VARICOSE VEINS	___	___
CHEMICAL DEPENDANCY	___	___	LIVER DISEASE	___	___	DO YOU USE ALCOHOL	___	___
DO YOU SMOKE	___	___	HEPATITIS	___	___	DO YOU USE ILLEGAL DRUGS	___	___

LIST ANY KNOWN ALLERGIES:_____

OTHER MEDICAL CONDITIONS: _____

ARE YOU UNDER A DOCTOR'S CARE NOW _____ IF YES EXPLAIN _____

LIST MEDICATIONS YOU TAKE _____ _____

FAMILY PHYSICIAN NAME _____ DATE LAST SEEN_____ PHONE_____

YOUR PHARMACY NAME _____ PHONE # _____

WHAT IS YOUR CHIEF FOOT OR ANKLE COMPLAINT TODAY? _____

_____

THIS CONDITION HAS EXISTED FOR: _____ DAYS _____ WEEKS _____ MONTHS _____ YEARS

PLEASE CIRCLE IF YOU HAVE THE FOLLOWING: ANKLE PAIN ATHLETE'S FOOT BUNIONS CORNS AND CALLUSES CRAMPS IN FEET OR LEGS

FLAT FEET HEEL PAIN INGROWN TOENAILS SWELLING IN FEET OR ANKLES KNEE PAIN UNEQUAL LEG LENGTH PLANTAR WARTS

ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE: _____

HAVE YOU BEEN TO A PODIATRIST BEFORE? NAME _____ LAST VISIT _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTORS OF FOOT AND ANKLE HEALTH GROUP TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND OR TREATMENT OF MY (OR MY DEPENDENT'S) FOOT OR ANKLE CONDITION(S). I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS TO MY INSURANCE COMPANY. I REQUEST ALL PAYMENTS TO BE ASSIGNED DIRECTLY TO THE DOCTORS OF FOOT AND ANKLE HEALTH GROUP. P.C. I REALIZE ALL UNPAID BALANCES , COPAYS, DEDUCTIBLES, AND NONCOVERED SERVICES ARE MY RESPONSIBILITY FOR PAYMENT.

SIGNATURE _____ DATE _____

Review Of Systems
Please check any of the following complaints that you have had in the last 6 months

Constitutional	**Cardiovascular**	**Gastrointestinal:**	**Respiratory**
__No problems	__No problems	__No problems	__No problems
__Weight loss	__Chest pain/ pressure	__Constipation	__Chronic cough
__Weight gain	__Rapid heart rate	__Diarrhea	__Wheezing
__Trouble sleeping	__Poor circulation	__Nausea / Vomiting	__Shortness of breath
__Fever	__Swelling in legs/ feet	__Blood in stool	__Coughing up blood
__Fatigue	__Irregular heart rate	__Abdominal pain	__Home oxygen use
Other:	Other:	Other:	Other
Musculoskeletal	**Neurological**	**Skin**	**Psychiatric**
__No problems	__No problems	__No problems	__No problems
__Joint pain	__Headache	__Rashes	__Depression
__Joint stiffness	__Recent falls	__Itching	__Anxiety
__Muscle spasms / cramps	__Poor memory	__Color change	__Frequent sadness
__Muscle weakness	__fainting	__Nail changes	__excessive worry
Other:	__Seizures	__Easy bruising	__Excessive stress
	Other:	Other:	Other:
Ear, nose, throat	**Eyes**	**Genitourinary**	**Endocrine**
__No problems	__No problems	__No problems	__No problems
__Snoring	__Blurred vision	__Blood in urine	__Heat intolerance
__Hearing loss	__Double vision	__Painful urination	__Cold intolerance
__Dizziness	__Eye pain	__Urine incontinence	__Appetite changes
__Ringing in ears	__Redness/ drainage	__frequent urination	__Abnormal sweating
__Nosebleeds	__Excessive watering	__kidney stones	__Hair loss
Other:	Other:	Other:	Other:

The following question are required by the federal government.

Do you smoke ___yes, ___never, ___former, ___Occasionally

What is your weight _____lbs

What is your height _____inches

What is your most recent blood pressure _____/_____mm

What is your race ___White, ___Black, ___ Asian, ___American Indian, ___declined

What is your ethnicity ___Hispanic, ___Non Hispanic, ___Declined

What is your primary language ___English, ___Spanish, ___French, ___Other_____

PLEASE PRINT YOUR NAME: _____

TODAYS DATE:_____