

Practice: Family Foot Care & Surgery, LLC.

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"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Liver	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Blood clot	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> other (specify) _____	<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="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

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

<b>Cardiovascular</b>	<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
<b>Genitourinary</b>	<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
<b>Gastrointestinal</b>	<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
<b>Integumentary</b>	<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
<b>Hematologic</b>	<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 disorder
					<input type="checkbox"/> NONE
<b>Neurological</b>	<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
<b>Musculoskeletal</b>	<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
<b>Respiratory</b>	<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

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_