MEDICAL HISTORY **FAMILY FOOT AND ANKLE CARE, P.C.**

Name_____ **DOB**_____ **Date**_____

Describe in your own words your Foot/Ankle problems:_____

Medical or Health Problems:_____

Hospitalizations/Surgeries:_____

Regular medications (including asprin) Dosage: _____

Are you in good health? ❑ Yes ❑ No

Do you have Arthritis? ❑ Yes ❑ No

Are you Pregnant or Nursing? ❑ Yes ❑ No

Do your feet get tired at the end of the day? ❑ Yes ❑ No

Do you have low back Pain? ❑ Yes ❑ No

Family History:

High Blood Pressure ❑ Yes ❑ No ❑ Mother ❑ Father

Heart disease ❑ Yes ❑ No ❑ Mother ❑ Father

Diabetes ❑ Yes ❑ No ❑ Mother ❑ Father

Foot problems ❑ Yes ❑ No ❑ Mother ❑ Father

If you have the following, or have had, please check: (✓)

❑ Yes ❑ No Anemia
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Asthma
❑ Yes ❑ No Blood Disease/Bleeding Problems
❑ Yes ❑ No Cramps or numbness in feet or legs
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Digestive Problems
❑ Yes ❑ No GI Reflux
❑ Yes ❑ No Gout
❑ Yes ❑ No Heart Problems
❑ Yes ❑ No Hepatitis
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No High Cholesterol
❑ Yes ❑ No HIV/Aids
❑ Yes ❑ No Kidney Disease/Stones
❑ Yes ❑ No Liver Trouble
❑ Yes ❑ No Migraines
❑ Yes ❑ No Phlebitis (blood clots in leg)
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Stroke
❑ Yes ❑ No Swelling in ankles or feet
❑ Yes ❑ No Varicose Veins

Other _____

I have a reaction to, or I am allergic to:

❑ Yes ❑ No Anesthetics (local)
❑ Yes ❑ No Asplrin
❑ Yes ❑ No Codeine
❑ Yes ❑ No Eggs
❑ Yes ❑ No Ibuprofin/Motrin/Advil
❑ Yes ❑ No Iodine
❑ Yes ❑ No Latex
❑ Yes ❑ No Metals
❑ Yes ❑ No Pain Pills
❑ Yes ❑ No Penicillin
❑ Yes ❑ No Shellfish
❑ Yes ❑ No Sulfa
❑ Yes ❑ No Tape

Other _____

Do you smoke or chew tabacco? ❑ Yes ❑ No packs per day?_____ For how many years?_____

Do you drink alcohol? ❑ Yes ❑ No _____Drinks per Day, Week, Socially, Holidays

Do you have any addictions? ❑ Yes ❑ No Drugs_____ Alcohol _____Other_____

Height:_____ Weight:_____ Age:_____ Shoe Size:_____

OFFICE USE ONLY: **Patient Signature:**_____ **Date:**_____

Physician:_____ Vital Signs: BP _____ Pulse_____ Resp _____ Temp _____

Interviewer: _____

07/08

Family Foot & Ankle Care, P.C.

Patient Name: _____ Patient's Social Security #: _____

Address (local): _____ Responsible Social Security #: _____

City: State: Zip: _____ 2nd Phone (cell or other): _____

Second Address: _____ Birth Date: _____/_____/_____ (Patient)

City: State: Zip: _____ Age: _____

Phone #: ( ) _____ Sex: M/F: _____

Email: _____ Driver's License #: _____

Responsible Party: _____ Marital Status: S M W D Sep

Relationship to Patient: _____

Responsible Phone #: _____ In Case of Emergency contact: _____

In Case of Emergency contact: _____ Emergency Phone #: _____

EMPLOYMENT INFORMATION

Patient's Employer: _____ Phone: _____

Spouse/Responsible Party Employer: _____ Phone: _____

INSURANCE INFORMATION - please allow us to copy your insurance ID cards

1. Primary Insurance Company: _____ Effective Date: _____

Insurance Company Address: _____ Relationship to Patient: _____

_____ Group # _____

Insurance Company Phone: _____ ID # _____

Insured or Employee Name: _____ Sex: M/F Insured Date of Birth: _____

---

2. Secondary Insurance Company: _____ Effective Date: _____

Insurance Company Address: _____ Relationship to Patient: _____

_____ Group # _____

Insurance Company Phone: _____ ID # _____

Insured or Employee Name: _____ Sex: M/F Insured Date of Birth: _____

ACCIDENT INFORMATION WORK, AUTO, HOME, OTHER _____

Date: _____ How/Where _____ Work Related: Yes No

_____ Have you filed a claim: Yes No

Were you treated by another Dr. for this injury? Yes No Doctor's Name: _____

Family Dr: _____ Phone # _____

Referred by: _____ (family, doctor, friend, insurance company, other) _____

Why are you in to see the doctor? _____

I HEREBY GIVE MY PERMISSION TO ADMINISTER TREATMENT, AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN DIAGNOSIS AND TREATMENT. I ALSO AGREE TO PAY FOR THE SERVICES IN THE FOLLOWING WAY: (please circle)

1. Cash or Check at the time of treatment.
2. Credit Card at time of treatment.
3. I will furnish insurance forms and information and I agree to pay my co-payment, deductible, and non-covered portions.
4. I hereby give permission to my physician to release records to process my insurance claims. I acknowledge that I was provided the opportunity to review the HIPPA Notice of Privacy Practices and understand my privacy will be protected to the HIPPA standards. _____ initial

WE RESERVE THE RIGHT TO CHARGE YOU FOR YOUR OFFICE VISIT IF 24 HOUR PRIOR NOTICE OF CANCELLATION IS NOT GIVEN. A MISSED APPOINTMENT HURTS THE CARE OF TWO PEOPLE: YOURS AS WELL AS THE PATIENT WAITING FOR AN APPOINTMENT. _____ initial

Patient Signature: _____ Date: _____

(Parent or Guardian if a minor)

03/12