WILMETTE FOOT & ANKLE CLINIC

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PATIENT INFORMATION FORM

1 PERTINENT INFORMATION

PLEASE PRINT

DATE _____

PATIENT NAME _____
first last mid. init.

DATE OF BIRTH _____ AGE ____ SEX: M F NB
month day year

HOME ADDRESS _____

CITY/STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

E-MAIL _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED
☐ PARTNERED ☐ SEPARATED
☐ DIVORCED ☐ WIDOWED

☐ ARE YOU A STUDENT / MINOR? (PLEASE REFER TO **SECT. 2***.)

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE _____

PRIMARY CARE DOCTOR _____

WHO REFERRED YOU TO US? _____

PHARMACY _____

LOCATION _____

PHONE _____

ADDITIONAL NOTES: _____

2 INSURANCE INFORMATION

PLEASE CIRCLE YOUR INSURANCE:

BLUE CROSS ASSURANT
MEDICARE CIGNA
UNITED HEALTH CARE HUMANA
OTHER _____
AETNA _____

NAME OF PERSON RESPONS. FOR ACCT / RELATIONSHIP **(GUARANTOR)**

_____

BIRTHDATE _____
month day year

***IF CHILD BEING TREATED, PERSON RESPONS. FOR ACCT/ RELATIONSHIP**

_____

BIRTHDATE _____
month day year

ADDRESS _____ PHONE _____

CITY/STATE _____ ZIP _____

3 PODIATRIC HISTORY

WHAT IS YOUR CHIEF COMPLAINT FOR WANTING TREATMENT? (INCLUDE FOOT, ANKLE, KNEE, THIGH AND HIP COMPLAINTS).

_____

_____

HAVE YOU BEEN TO A PODIATRIST BEFORE? YES NO

DOCTOR'S NAME _____

LAST VISIT _____

PLEASE INDICATE WHICH FOOT PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST.

☐ ANKLE PAIN
☐ ATHLETE'S FOOT
☐ CORNS & CALLUSES
☐ CRAMPS OR NUMBNESS IN FEET OR LEGS
☐ FLAT FEET
☐ FOOT OR LEGS CRAMPS
☐ HEEL PAIN
☐ INGROWN TOENAILS
☐ PLANTAR WARTS
☐ SWELLING IN ANKLES OR FEET
☐ TIRED FEET
☐ NAIL CONCERNS _____

4 MEDICATIONS

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

NAME	DOSE	HOW OFTEN IS IT TAKEN?

5 PLEASE LIST PRIOR SURGERIES

TYPE OF SURGERY	DATE

6 PRIOR HOSPITALIZATIONS

LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN SURGERY)	DATE

7 ALLERGIES

- ☐ ADHESIVE TAPE
- ☐ ANTICOAGULANT THERAPY
- ☐ ASPIRIN
- ☐ CODEINE
- ☐ DEMEROL
- ☐ IODINE
- ☐ LOCAL ANESTHETICS
- ☐ NOVOCAINE
- ☐ PENICILLIN
- ☐ SEAFOODS
- ☐ SULFA

OTHER _____

8 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 ☐ MODERATE ☐ DAILY

EMPLOYER _____ **OCCUPATION** _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN - AGE(S) _____ ☐ PET(S) - WHAT KIND? _____

☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE _____

9 MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART ATTACK / FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	PSYCHIATRIC CARE	Y	N
BLADDER INFECTIONS	Y	N	HIV+ / AIDS	Y	N	RHEUMATIC FEVER	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SICKLE CELL DISEASE	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SKIN DISORDER	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	SLEEP APNEA	Y	N
BRONCHITIS / EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STOMACH ULCERS	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	STROKE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	THYROID DISEASE	Y	N
						TUBERCULOSIS	Y	N
						VASCULAR CONCERNS	Y	N

OTHER CONDITIONS _____

10 FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

- ☐ DIABETES
- ☐ CANCER
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ RHEUMATOID ARTHRITIS
- ☐ CORONARY ARTERY DISEASE
- ☐ OTHER _____

11 CURRENT PROBLEM

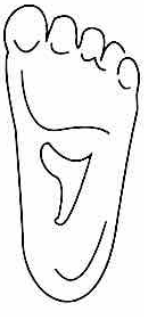
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

_____

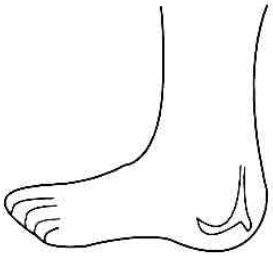
WHERE IS THE PAIN / PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

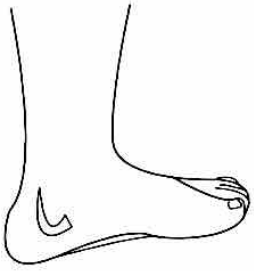
TOP OF FOOT



BOTTOM OF FOOT

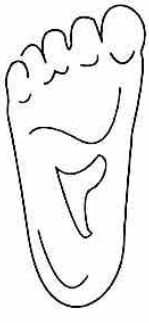


OUTSIDE OF FOOT



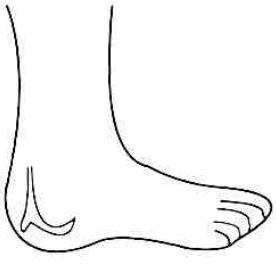
INSIDE OF FOOT

RIGHT FOOT

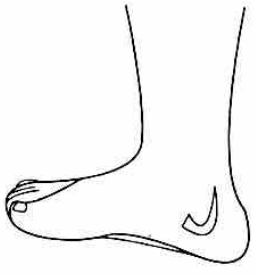


BOTTOM OF FOOT

TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

11 CURRENT PROBLEM, *continued*

WHEN DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER

HOW WOULD YOU RATE YOUR PAIN ON A SCALE OF 0 TO 10? (*PLEASE CIRCLE*)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT ☐ STAYED THE SAME ☐ BECAME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES DESCRIBE _____

IF YES, WAS IT A WORK-RELATED INJURY? YES ☐ NO ☐

_____

TREATMENT CONSENT

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.

I HEREBY GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

_____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN **SIGNATURE** **DATE**

_____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT **DATE**

_____

INFORMATION REVIEWED BY PODIATRIST **SIGNATURE** **DATE**

FOR OFFICE STAFF: IF PATIENT DOESN'T HAVE OR DOES NOT WISH TO USE THEIR INSURANCE, MAKE A COPY OF THE DRIVER'S LICENSE OR STATE ID, AND ALSO WRITE THE NUMBER IN THE SPACE BELOW.

Gary Rogers, D.P.M.
Podiatric Physician & Surgeon

& Associate

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:_____

Printed Name: Patient or Representative

_____ _____

Signature Date

Relationship to Patient
(if other than Patient) _____

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