WELCOME TO OUR OFFICE

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SURGICAL & ORTHOPEDIC
MANAGEMENT OF FOOT DISORDERS

Name ______________________________ Soc. Sec. No. ______________

Date of Birth ______________ Age _____ ❑ Male ❑ Female Marital Status ______

Home Address______________ City ____________ State_____ Zip Code _____

Home/Cell Phone ________ Work Phone __________ Preferred Pharmacy__________

Email Address____

Race: ❑ Not Specified ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino

How would you like to be contacted regarding health information: ❑ Phone ❑ Email ❑ Mail

Who are we able to talk to on the phone: ❑ Patient only ❑ Patient and/or Spouse ❑ Anyone Answering the Phone

Name of Spouse or Parent____

Next of Kin/Emergency Contact (name and phone) ______________________________

How were you referred to the office? Patient ______ Doctor's Office ______ Other ______

Family Doctor ____________ Date of last visit ______ Other (if checked above) ______

Employer ____________________ Employer Phone Number ______________

Employer Address ________________________ Position ________________

INSURANCE INFORMATION

Type of Insurance ________________ Policyholder ______________________

Policyholder Birth date ______________ Policyholder Soc. Sec. No. ______________

Policyholder Address ____

Relationship to Patient ______________ Policyholder Employer ________________

Employer Address ____

Employer Contact & Phone Number ____________________________________

Name: ____________________
Date of Birth: ____________________
Date: ____________________

CHIEF COMPLAINT - Why are you coming to the doctor today?

____

Is this condition work related? ❑ Yes ❑ No   Did this injury occur at school? ❑ Yes ❑ No

Is this condition auto related? ❑ Yes ❑ No   Injury or Trauma? ❑ Yes ❑ No
Date of Injury: __________   What happened? ____________________

____

Type of Problem

❑Corns, Callous, Nails   ❑ Fracture/Sprains   ❑ Warts, Tumors   ❑ Bunions, Hammertoes
❑Diabetic Foot Care   ❑ Ingrown Nail   ❑ Ankle Pain   ❑ Neuroma or Nerve Pain
❑Other   ❑ Injury   ❑ Numbness
When did the pain start? __________ Describe Pain. __________

Where does it hurt? ❑ Right ❑ Left ❑ Both   When does it hurt? __________

____________________   ____________________

Previous episodes? __________ Previous treatment and response? __________

____

Allergies Do you have any allergies to medications / environment / food? ❑ Yes ❑ No
❑ NSAIDS   ❑ Penicillin   ❑ Sulfa   ❑ Codeine   ❑ Aspirin
❑ Novacaine   ❑ Anesthetics   ❑ Iodine   ❑ Adhesives   ❑ Metal or Nickel
❑ Environmental   Other: __________   Type of reaction __________
Are you allergic to latex products?   ❑ Yes   ❑ No

Medications List all prescription medications you take; include dosage and frequency. Insulin, inhaler, and patches should be included here.

____
____
____

List all non-prescription medications you take routinely ____________________

Past Medical History Do you have a history of any of the following?

❑ High Blood Pressure   ❑ Diabetes   ❑ Stroke   ❑ Nervousness   ❑ Tumors
❑ Heart/Circulation Trouble   ❑ Hypoglycemia   ❑ Emphysema   ❑ Epilepsy   ❑ MRSA
❑ Glaucoma   ❑ Kidney Disease   ❑ Ulcers   ❑ HIV/AIDS   ❑ Hepatitis
❑ Rheumatism/Arthritis   ❑ Liver Disease   ❑ Asthma   ❑ Anemia   ❑ Gout
❑ Bleeding Tendencies   ❑ Thyroid Disease   ❑ Varicose Veins   ❑ Tuberculosis
❑ Osteoporosis   ❑ Blood Clot   ❑ Cancer Type: __________
❑ Mitral Valve Prolapse   ❑ Leg Cramps   ❑ Parkinson's   ❑ Other: __________

____

Past Surgical History Have you had any surgery before?   ❑ Yes   ❑ No
If yes, please list procedure and date ____________________

____
____

Are you Disabled? ❑ Yes ❑ No   Type / Nature of Disability __________

Name: ____ Date of Birth: ________________

Family History List illnesses or health issues. Any Family History of:
Mother's Side of the family: ❑ Blood Clot ❑ Diabetes ❑ High Blood Pressure ❑ Cancer
❑ Other: ____
Father's Side of the family: ❑ Blood Clot ❑ Diabetes ❑ High Blood Pressure ❑ Cancer
❑ Other: ____

Social History Marital Status ________ Shoe Size ________ Patient's Age_________

Do you or have you ever smoked? ❑ Yes ❑ No How Much __________
**If you quit smoking, how long ago did you quit?* ______________________
Do you drink alcohol? ❑ Yes ❑ No How Much __________
Do you or have you ever used illegal substances? ❑ Yes ❑ No ❑ Current User ❑Former User
What type of current/former occupation do/did you have? __________________________________

CONSTITUTIONAL
❑ Fever
❑ Weight loss
(intentional/unintentional)
❑ Fatigue

CARDIOVASCULAR
❑Chest pain (angina)
❑ Heart palpitations
❑ Heart attack
❑ Stroke
❑ Cold extremities
❑ High Blood Pressure
❑ Congestive Heart Failure
❑ High Cholesterol

ENDOCRINE
❑ Night sweats
❑ Thyroid disease
❑ Diabetes
❑ Heat/Cold intolerance
❑ Frequent thirst

GASTROINTESTINAL
❑ Pain
❑ Diarrhea
❑ Constipation
❑ Heartburn
❑ Food intolerance
❑ History of Ulcers
❑ GI Intolerance

GENITOURINARY
❑ Frequent urination
❑ Frequently blood in urine
❑ Painful urination
❑ Incontinence

INTEGUMENTARY
❑ Rash
❑ Itching
❑ Dry Skin
❑ Toenail/Fingernail changes

HEMATOLOGIC/LYMPHATIC
❑ Easy bruising
❑ Anemia
❑ Blood abnormalities
❑ Blood thinners
❑ HIV / AIDS
❑ Hepatitis

MUSCULOSKELETAL
❑ Pain -
❑ Muscles ❑ Neck
❑ Back ❑ Hips
❑ Knees ❑ Ankles ❑ Feet
❑ Limited range of motion
❑ Limited strength
❑ Arthritis
❑ Gout
❑ Fibromyalgia

NEUROLOGICAL
❑ Headache
❑ Fainting
❑ Dizziness
❑ Memory loss
❑ Numbness

PSYCHIATRIC
❑Temper
❑ Dementia
❑Bipolar
❑Depression
❑Anxiety
❑Alzheimer's disease

RESPIRATORY
❑ Shortness of breath
❑COPD
❑Asthma
❑ Emphysema
❑ Sleep apnea

Are your Immunizations Up-to-date: ❑ Yes ❑ No

Any medical conditions with your Eyes, Ears, Nose, and Throat: ____________________________
____

Unmarked box indicates that the patient denies this problem.

FAMILY FOOT HEALTH CARE, PLC
927 W 4TH ST
WATERLOO, IA 50702

Please read and initial / mark that you read the following:

_______ As a Waiver of Liability, I understand that Medicare or any other insurance may or may not cover my Provider's fees and I am responsible for payment.

_______ I authorize use of this form on all my insurance submissions.

_______ I authorize release of information to all my insurance companies.

_______ I authorize my provider to act as my agent in helping me obtain payment from my insurance companies.

_______ I permit a copy of this authorization to be used in place of the original.

_______ I hereby acknowledge that I was offered the opportunity to review and/or keep a copy of our Notice of Privacy Practices.

____
Patient Name (PLEASE PRINT)

____
Parent or authorized representative (if applicable)

____ _______________
Signature Date

Due to HIPAA regulations, please choose one of the following options.

- ❑ I don't want to disclose my records to anyone.
- ❑ I want to disclose my records to the following person(s). {Not all lines have to be filled and you can add more than four.}

Name	Phone #	Relationship
Name	Phone #	Relationship
Name	Phone #	Relationship
Name	Phone #	Relationship

____ _______________
Signature Date