Family Foot
— Health Care PLC —

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MANAGEMENT OF FOOT DISORDERS & Ankle 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