

**Practice Name:** \_\_\_\_\_

**Chart Number:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Race:** \_\_\_\_\_  
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

I prefer not to answer       I do not know

**Ethnicity:** \_\_\_\_\_

I prefer not to answer       I do not know

**Preferred Language:** \_\_\_\_\_

I prefer not to answer

### Privacy Information Preferences

Did you receive a copy of the HIPAA Privacy Practice Notice:       Yes       No

Would you like your information to be confidential within our office and not included when the government requires us to file statistical reports on our patients?       Yes       No

Can we send mail to the address on file?       Yes       No

Can we call the phone number on file?       Yes       No

Can we leave voicemail on answering machine?       Yes       No

Will you allow internet based delivery reminders like email?       Yes       No

Who may we leave messages with?       Wife       Husband       Daughter       Son

Other: \_\_\_\_\_

### Smoking Status

- Current Every Day Smoker       Smoker, Current  
 Current Some Day Smoker      status unknown  
 Former Smoker  
 Never Smoker       Unknown if ever  
 I decline to answer      smoked

### Vital Signs

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

I prefer not to answer       I do not know

### Current Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am not taking medication       I prefer not to answer

### Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I do not have allergies       I prefer not to answer

# 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"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney
<input type="checkbox"/> Blood clot	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes (type 1, type 2)	
<input type="checkbox"/> Neurological (specify) _____	<input type="checkbox"/> Thyroid (specify) _____	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin disorders (specify) _____	
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> Other (specify) _____			

**Are you pregnant?**  Yes  No      **Are you nursing?**  Yes  No

**Surgical History**  Yes  No  
 Have you ever had any surgical procedures on foot/ankle or anywhere else on your body?  
 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? \_\_\_\_\_ 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?  Yes, I do the following regular exercise: \_\_\_\_\_  
 No, I do not exercise regularly

**Family History** Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Arthritis Type	<input type="checkbox"/> Cancer Type	<input type="checkbox"/> Flatfeet	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Hammer toes
<input type="checkbox"/> Blood clot/DVT/PE	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Bunions	<input type="checkbox"/> Neurological	<input type="checkbox"/> Strokes
<input type="checkbox"/> Other (specify): _____					

**Current Medications**  None  I take the following Prescription or over the counter medications:

Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____
Name: _____	Dose _____	How often? _____

Use the back of this form if more room is needed

**Allergy**  No Known Allergies      **Reaction**

<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Shellfish	_____
<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Tape	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Betadine (iodine)	_____
<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Tylenol™	_____
<input type="checkbox"/> Ibuprofen	_____
<input type="checkbox"/> Codeine	_____
<input type="checkbox"/> Other (specify) _____	_____

**Review of Systems** (Please check the box if you currently have any of these symptoms)

<b>Cardiovascular</b>	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> nausea	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain	<input type="checkbox"/> chest pressure/angina
	<input type="checkbox"/> vomiting	<input type="checkbox"/> chills	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	<input type="checkbox"/> weight gain/weight loss
	<input type="checkbox"/> leg cramps	<input type="checkbox"/> high blood pressure/hypertension			
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> decreased frequency	
<b>Gastrointestinal</b>	<input type="checkbox"/> currently pregnant	<input type="checkbox"/> excessive urination	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	
<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	
<input type="checkbox"/> diarrhea	<input type="checkbox"/> indigestion				
<b>Integumentary</b>	<input type="checkbox"/> athletes foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
<b>Hematologic</b>	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> rash	<input type="checkbox"/> anemia
	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> use of blood thinners			
<b>Neurological</b>	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis	<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
<b>Respiratory</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> arthritis	<input type="checkbox"/> wheezing	
	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	<input type="checkbox"/> shortness of breath		

Practice: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart Number: \_\_\_\_\_  
Sex:  M  F Marital Status:  Single  Married  Widowed  Divorced SS#: \_\_\_\_\_  
Spouse/Partner Name: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Are you the insured?  Yes  No  
Policy ID: \_\_\_\_\_

**Insured Information**

Subscriber Name: \_\_\_\_\_ Relationship to insured:  Spouse  Child  Self  Other  
Address: \_\_\_\_\_  
Group ID: \_\_\_\_\_ Sex:  Male  Female DOB: \_\_\_/\_\_\_/\_\_\_  
Phone #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Are you the insured?  Yes  No  
Policy ID: \_\_\_\_\_

**Insured Information**

Subscriber Name: \_\_\_\_\_ Relationship to insured:  Spouse  Child  Self  Other  
Address: \_\_\_\_\_  
Group ID: \_\_\_\_\_ Sex:  Male  Female DOB: \_\_\_/\_\_\_/\_\_\_  
Phone #: \_\_\_\_\_

How did you find out about our practice?  Physician  Internet  Telephone book  Family member  Friend  
 Other: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

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. \_\_\_\_\_