

NORTHWEST PODIATRY CENTER

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WELCOME: Thank you for choosing Northwest Podiatry Center for your foot care needs. Below are questions to help us get better acquainted and provide information vital to your health. Please feel free to discuss matters of a private nature with the doctor. This information will be kept confidential.

PATIENT INFORMATION

NAME: (LAST) _____ (FIRST) _____ (M.I.) _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____ - _____

HOME PHONE#: _____ WORK PHONE#: _____ CELL PHONE#: _____

MAY WE E-MAIL INFORMATION TO YOU? NO YES EMAIL ADDRESS _____

MAY WE TEXT INFORMATION TO YOU? NO YES

BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY#: _____ MALE FEMALE

EMPLOYER: _____ EMPLOYER ADDRESS: _____ OCCUPATION: _____

Race: _____ Ethnicity: _____ HT: _____ WEIGHT: _____ SHOE SIZE: _____

SINGLE MARRIED WIDOWED SEPARATED DIVORCED

Is there a family member or other person you would like us to release medical information to: _____

RELATIONSHIP TO PATIENT: _____ PHONE# (_____) _____

IF PATIENT IS A MINOR (under 18)

FATHER NAME: Last _____ First _____ M.I. _____ MOTHER NAME: Last _____ First _____ M.I. _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE# _____ CELL PHONE# _____ HOME PHONE# _____ CELL PHONE# _____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? YES NO CLAIM# _____ ADJUSTER INFORMATION _____

YOUR PRIMARY INSURANCE CO.: _____ ID# _____ GROUP# _____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS DATE OF BIRTH _____ POLICY HOLDERS SS# _____

CO-PAY: YES NO AMOUNT OF CO-PAY: \$ _____

DO YOU HAVE SECONDARY INSURANCE? YES NO

NAME OF SECONDARY INSURANCE COMPANY: _____ ID# _____ GROUP# _____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS DATE OF BIRTH _____ POLICY HOLDERS SS# _____

OFFICE VISIT INFORMATION

WHAT BRINGS YOU TO THE OFFICE TODAY _____

HOW LONG HAS IT BOTHERED YOU? DAYS WEEKS MONTHS YEARS

ANY PAST PROBLEMS WITH YOUR FEET OR ANKLES? YES NO PLEASE DESCRIBE _____

HOW WERE REFERRED TO OUR OFFICE? _____

YELLOW PAGES INSURANCE DIRECTORY INTERNET AD FRIEND PATIENT DOCTOR RELATIVE

****PLEASE COMPLETE ALL INFORMATION ON BOTH SIDES OF FORM ****

MEDICAL INFORMATION

WOULD YOU LIKE YOUR PODIATRIC REPORT SENT TO YOUR MEDICAL DOCTOR? YES NO

FAMILY DOCTOR NAME: _____ LAST VISIT: _____

ADDRESS: _____ PHONE# (____) _____ FAX#(____) _____

PHARMACY NAME _____ Phone _____ Fax _____

PHARMACY ADDRESS _____

ARE YOU TAKING ANY MEDICATIONS? YES NO PLEASE PROVIDE LIST OR FILL IN BELOW

NAME OF MEDICATION	DOSAGE

ARE YOU ALLERGIC TO: ASPIRIN BETADINE (IODINE) CODEINE IBUPROFEN PENICILLIN SULFA TAPE OR BAND-AID TYLENOL
 OTHER: _____ NO KNOWN DRUG ALLERGIES

DO YOU HAVE OR HAVE YOU HAD A PROBLEM WITH ANY OF THE FOLLOWING? NONE

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Chronic Renal Disease | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Convulsion / Seizures | <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes/ High Sugar | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> M.I. |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Polio | <input type="checkbox"/> Recent Cold | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> GERD | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Other |

HAVE YOU HAD ANY SURGICAL PROCEDURES OTHER THAN FOOT OR ANKLE? YES NO

IF YES PLEASE DESCRIBE: _____

DO YOU HAVE ANY ARTIFICIAL JOINTS? YES NO

DO YOU HAVE A HEART VALVE IMPLANT? YES NO

SOCIAL HISTORY:

DO YOU SMOKE? 1/2 PACK PER DAY 1 PACK PER DAY 1 1/2 PACKS PER DAY + NEVER SMOKED

ARE YOU A FORMER SMOKER NO YES IF YES WHEN DID YOU QUIT SMOKING? _____

DO YOU USE RECREATIONAL DRUGS NO YES

DO YOU DRINK? NO SOCIALLY 1 DRINK PER DAY 2 DRINKS PER DAY+

FAMILY HISTORY: MOTHER _____
 FATHER _____
 BROTHER _____
 SISTER _____

IS THERE A FAMILY HISTORY OF BLOOD CLOTS? YES NO

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE: _____ RELATIONSHIP: MOTHER FATHER OTHER