GENTLE FOOT CARE

Treatment & surgery of the foot and ankle

www.gentlefootcare.biz

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DATE: ____/_____/_____

PATIENT NAME: _________________ _________________ ____ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F
Last First MI
Home Address:____SSN___________________

CITY/STATE: ________________________ ZIP: _____________

HOME PHONE #: (_____) _____-________ MAY WE LEAVE A MESSAGE? YES NO
ALTERNATE PHONE #: (_____) _____-________ MAY WE LEAVE A MESSAGE? YES NO
E-MAIL: ____________________________________ MAY WE LEAVE A MESSAGE? YES NO
PRIMARY LANGUAGE: _________________________ ETHNICITY________________________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _________________________RELATIONSHIP: _____________ PHONE #: (_____) _____-_______

EMERGENCY CONTACT: ____________________RELATIONSHIP: _____________ PHONE #: (_____) _____-_______

PRIMARY CARE DOCTOR: _______________________ PHONE #: ______________________________

WHO (EX: NAME OF DOCTOR, FRIEND, INTERNET) REFERRED YOU TO US?_________________________________

PHARMACY: ________________________________ZIP______________ PHONE #: (_____) _____-_______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
___YES NAME(S) ____ ____ NO
WHO IS RESPONSIBLE FOR PAYMENT? _____________________________ RELATIONSHIP TO PATIENT? ________________
ADDRESS: _______________________ CITY/STATE: _________________ ZIP: _________ PHONE #: (_____) _____-______

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME____
ADDRESS: ____
CITY/STATE: _________________ ZIP: _______________ PHONE #: (_____) _____-______
INSURED NAME: ___________________________________ DATE OF BIRTH ____________________
RELATIONSHIP TO PATIENT _____________________________________ SSN: ___________________________
EMPLOYER _________________________________ CONTRACT # ________________________ GROUP # ______________

SECONDARY INSURANCE COMPANY NAME____
ADDRESS: ____
CITY/STATE: _________________ ZIP: _________ PHONE #: (_____) _____-______
INSURED NAME: ___________________________________ DATE OF BIRTH ______________
RELATIONSHIP TO PATIENT _____________________________________ SSN: ___________________________
EMPLOYER _________________________________CONTRACT # __________________ GROUP # ____________________

SOCIAL HISTORY

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

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ NUMBER OF DRINKS PER WEEK - _____

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? __________ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? __________ TYPE __________________

EMPLOYER: ____ OCCUPATION: ____________________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE________
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER

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

TYPES OF EXERCISE:

____

HEIGHT ________ FEET _________ INCHES **WEIGHT** ____________POUNDS **SHOE SIZE**____________

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: FAMILY MEMBER (EXAMPLE: MOTHER, FATHER, SISTER)

☐ DIABETES ___________________ ☐ STROKE ___________________
☐ CANCER ___________________ ☐ RHEUMATOID ARTHRITIS ___________________
☐ HEART DISEASE ___________________ ☐ OTHER ___________________
☐ HIGH BLOOD PRESSURE ___________________

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

____
____
____
____
____
____

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

NAME DOSE REASON?

____
____
____
____
____
____
____
____
____
____
____
____
____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS (LIST BELOW)

____

☐ ANESTHESIA ______________________________ ☐ FOODS___________________________

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ___________________________________

Medical Problems: **Which of the following conditions are you currently being treated or have been treated for in the past (please check)**

☐Heart disease / Murmur / Angina ☐Shortness of breathe ☐Eye disorder / Glaucoma ☐Diabetes ☐High cholesterol ☐Asthma

☐Seizures ☐Kidney / Bladder problems ☐High blood pressure ☐Lung problems / cough/ COPD ☐Stroke ☐Liver problems / Hepatitis

☐Low blood pressure ☐Sinus problems ☐Headaches / Migraines ☐Arthritis (rheumatoid or osteoarthritis)☐Heartburn (reflux)

☐Seasonal allergies ☐Neurological problems ☐Cancer ☐Anemia or blood problems ☐Tonsillitis ☐Depression / Anxiety ☐Ulcers/colitis

☐Hepatitis ____ ☐Swollen ankles ☐Ear problems ☐Psychiatric care ☐Thyroid problems ☐Infectious Disease (HIV, AID's)

Others/any additional information regarding your medical conditions

____

____

____

Review of Systems: circle or write in any symptoms that apply to you currently

Constitutional: (nausea, recent illness, fever, chills, night sweats, anorexia, fatigue, insomnia, weight gain/loss)____________________

Eyes (visual changes, cataract, glaucoma, discharge, injuries, glasses or contacts)_______

Head, Ears, Nose, Throat (head injuries, headache, dizziness, difficulty with hearing, pain, discharge, ear infections, ventilation tubes, sinus congestion, sore throat, discharge: watery or purulent, difficulty in breathing through nose, bloody nose, sore throat or tongue, difficulty in swallowing, dental defects, swollen glands, masses) ______________

Lungs(shortness of breath, ability to keep up with peers, cough, wheezing)______________

Heart (cyanosis, arrhythmia, edema, heart murmurs or "heart trouble," pain over heart), ______________

Gastrointestinal (nausea, vomiting, abnormal bowel movements, abdominal pain, jaundice,reflux)_______

Genitourinary (dysuria, hematuria, urethral or vaginal discharge, sores, pain, venereal disease, pregnant, abortions)________________

Musculoskeletal (back pain, stiffness, swelling, muscle weakness, deformities, difficulty in moving extremities or in walking, joint pains and swelling, muscle pains or cramps)_____

Skin (skin cancer, rashes, calluses, nail changes, psoriasis, cellulitis, skin color change, abnormal moles, easy bruising or bleeding)______________

Neurologic (headaches, fainting, dizziness, seizures, numbness, tremors)___________________

Psychiatric (nervousness/anxiety, drug use or abuse, psycosis, suicidality)__________

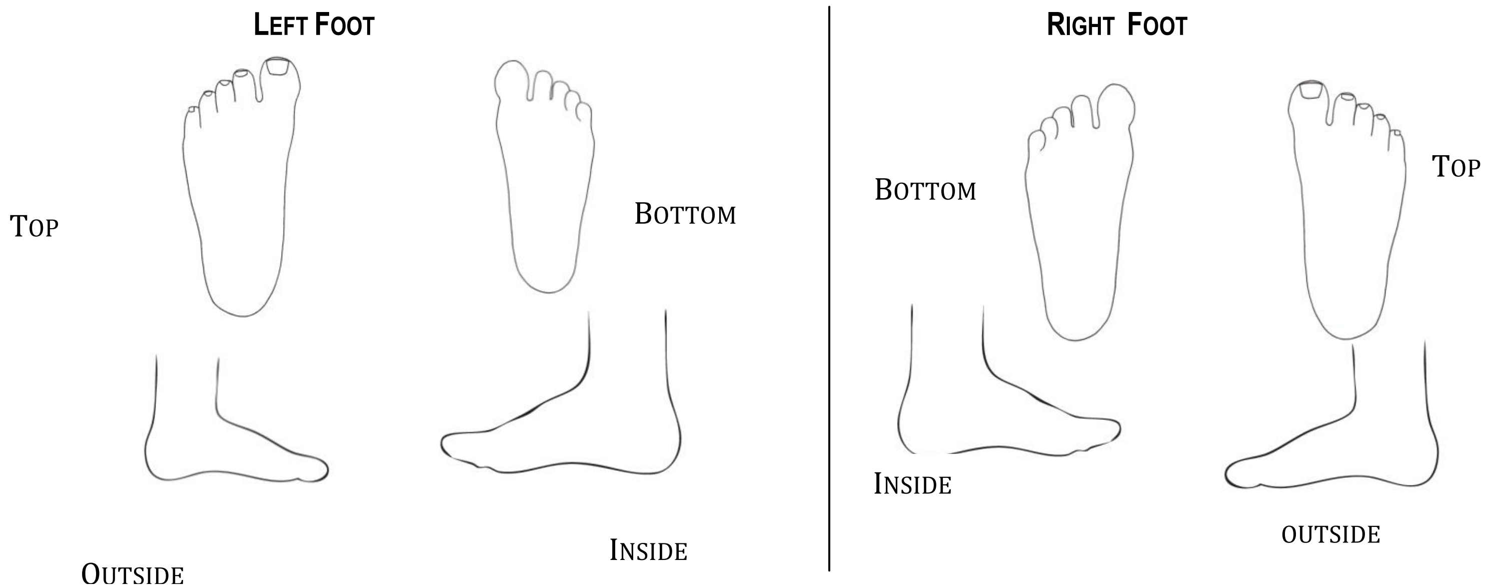
Endocrine: Hypo/Hyper-thyroid, hyperglycemic/diabetes

CURRENT PROBLEM (CHIEF COMPLAINT)

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

____

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



HOW LONG AGO 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 DESCRIBE YOUR PAIN? (PLEASE CIRCLE) *NO PAIN* *MILD PAIN* *MODERATE PAIN* *SEVERE PAIN*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME 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 BELOW) ☐ NO
____
____
____
____

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.

____ DATE ______

____
SIGN NAME OF PATIENT, PARENT OR GUARDIAN REVIEWED BY