Practice: **FOOT & ANKLE ASSOCIATES OF LANCASTER** **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

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

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐ Yes ☐ No

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: _____

PLEASE READ AND SIGN

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.

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____ 2

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ Other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin Disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body ☐ Yes ☐ No
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? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 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? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

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

☐ Alzheimer's _____ ☐ Depression _____
☐ Arthritis _____ ☐ Diabetes _____
☐ Bleeding disorders _____ ☐ Emphysema _____
☐ Blood clot _____ ☐ Heart disease _____
☐ Cancer _____ ☐ High Blood Pressure _____
☐ Cataracts _____ ☐ Neurological _____
☐ Circulation problems _____ ☐ Strokes _____
☐ Other *(specify)*: _____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking ☐ fainting	☐ fever ☐ palpitations	☐ chest pain/pressure ☐ vascular disease	☐ leg swelling ☐ valve problems	☐ cold hands/feet ☐ **NONE**
Genitourinary	☐ blood in urine ☐ decreased frequency	☐ hesitancy ☐ excessive urination	☐ Incontinence ☐ kidney disease	☐ increased urgency ☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain ☐ diarrhea	☐ heatrburn ☐ trouble swallowing	☐ blood in stool ☐ decrease appetite	☐ vomiting	☐ ulcers ☐ increase appetite ☐ constipation ☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling ☐ tremors	☐ weakness ☐ paralysis	☐ seizures	☐ numbness	☐ headaches ☐ **NONE**
Musculoskeletal	☐ back pain ☐ sciatica	☐ joint swelling ☐ joint stiffness	☐ muscle weakness ☐ joint pain	☐ muscle pain ☐ joint instability	☐ arthritis ☐ neck pain ☐ **NONE**
Respiratory	☐ chest pain ☐ shortness of breath	☐ wheezing ☐ emphysema	☐ COPD	☐ coughing	☐ snoring ☐ **NONE**

PLEASE READ AND SIGN
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.

Patient Signature: _____ Date: _____

Practice: **FOOT & ANKLE ASSOCIATES OF LANCASTER** **Today's Date:**

Name: _____ **Chart #:** _____ **Date of Birth:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Prefered Language: _____ ☐ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ 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 machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____/_____

Height: _____ Weight: _____

Current medications

☐ No Known Medications ☐ I take the following Medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) 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. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Patient Name: _____(Page 4)

***** Shoe Size _____*****

If you are age 65 and older.....
~Have you fallen within the last 12 months? _____
~Were you injured from the fall? _____

_____

Please answer.....

Advance Directives: OR LIVING WILL –

_____ The Patient has NOT completed any advanced directives.

_____ The Patient has completed a living will order.

_____ The Patient has completed a durable power of attorney order.

Please read and sign:

I hereby give my express consent to Foot & Ankle Associates or any business associated with Foot & Ankle Associates to contact me on a telephone number provided, regardless of whether the telephone number is associated with a cell phone or any other telephone, lawfully obtaining this number through e-mail, text message or other electronic communication. These contacts may be necessary to enforce any part of this agreement to collect any outstanding balance on the account created under this agreement. For greater efficiency calls may be delivered by an autodialer and or pre-recorded message.

Name : _____Date _____