Practice: FAMILY FOOT CENTER **Today's Date:**

History and Physical **Name**_____ **Chart Number:**_____

Medical History:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Auto Immune Disease
- ❑ Blood Disorder
- ❑ Depression
- ❑ Emphysema
- ❑ Diabetes ❑ Type 1 ❑ Type 2
- ❑ Epilepsy
- ❑ Eye Pathology
- ❑ GI Ulcers
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ HIV
- ❑ Hyper Cholesterol
- ❑ Hyper Thyroidism
- ❑ Hypo Thyroidism
- ❑ Kidney Disease
- ❑ Leg Cramps / Numbness
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Parkinson's Disease
- ❑ Peripheral Vascular Disease
- ❑ Shortness of Breath
- ❑ Skin Disorder
- ❑ Stroke
- ❑ Varicose Veins
- ❑ Cancer Specify_____
- ❑ Other_____

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

Surgical History:

- ❑ Angioplasty
- ❑ Appendectomy
- ❑ Arterial Bypass Sx
- ❑ Back Sx
- ❑ Breast Biopsy
- ❑ C-Section
- ❑ Cataract
- ❑ Carotid Artery
- ❑ D&C
- ❑ Gall Bladder Sx
- ❑ Hernia Repair
- ❑ Hip Replacement
- ❑ Hysterectomy
- ❑ Knee Replacement
- ❑ Knee Sx
- ❑ Mastectomy
- ❑ Open Heart Sx
- ❑ Pacemaker
- ❑ Prostate Sx
- ❑ Skin Cancer Sx
- ❑ Thyroid Sx
- ❑ Tonsillectomy
- ❑ Venous Ligation
- ❑ Other_____
- ❑ Foot Surgery_____

Do you have any artificial joints? ❑ Yes (where? _____) ❑ No Do you have an artificial heart valve? ❑ Yes ❑ No

Family History:

	Mother	Father	Siblings		Mother	Father	Siblings
Alzheimer's	Yes	Yes	Yes	Diabetes	Yes	Yes	Yes
Arthritis	Yes	Yes	Yes	Emphysema	Yes	Yes	Yes
Bleeding disorders	Yes	Yes	Yes	Heart disease	Yes	Yes	Yes
Blood clot	Yes	Yes	Yes	High Blood Pressure	Yes	Yes	Yes
Cancer	Yes	Yes	Yes	Neurological	Yes	Yes	Yes
Circulation problems	Yes	Yes	Yes	Parkinsons	Yes	Yes	Yes
Depression	Yes	Yes	Yes	Strokes	Yes	Yes	Yes

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	❑ fever	❑ chest pain/pressure	❑ leg swelling	❑ cold hands/feet
	❑ fainting	❑ palpitations	❑ vascular disease	❑ valve problems	❑ **NONE**
Genitourinary	❑ blood in urine	❑ hesitancy	❑ incontinence	❑ increased urgency	
	❑ decreased frequency	❑ excessive urination	❑ kidney disease	❑ kidney stones	❑ **NONE**
Gastrointestinal	❑ abdominal pain	❑ heartburn	❑ blood in stool	❑ vomiting	❑ ulcers ❑ constipation
	❑ diarrhea	❑ trouble swallowing	❑ decrease appetite	❑ increase appetite	❑ **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	❑ weakness	❑ seizures	❑ numbness	❑ headaches
	❑ tremors	❑ paralysis			❑ **NONE**
Musculoskeletal	❑ back pain	❑ joint swelling	❑ muscle weakness	❑ muscle pain	❑ neck pain
	❑ sciatica	❑ joint stiffness	❑ Joint pain	❑ joint instability	❑ arthritis ❑ **NONE**
Respiratory	❑ Chest pain	❑ wheezing	❑ COPD	❑ coughing	❑ snoring
	❑ shortness of breath	❑ emphysema			

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: FAMILY FOOT CENTER 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:_____

Northern 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:____/___/___

Secondary Insurance:_____

How did you find out about our practice?

❑ Physician ❑ Internet ❑ Ad ❑ Family member ❑ Friend ❑ Walk by ❑ Insurance ❑ Other:_____

Specify_____

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:_____

Shoe Size:_____ Have you ever worn custom made arch supports? (Orthotics) ❑ Yes ❑ No

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)_____

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: FAMILY FOOT CENTER **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

Preferred Language: _____ ❑ Declined to specify

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

Pharmacy Address: _____ City, State, Zip: _____

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

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

Diabetic Physician: _____ Phone: _____ Date Last Seen: _____

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: _____

_____

Current Medications

❑ No Known Medications ❑ I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Allergies

❑ No Known Allergies ❑ No Known Drug Allergies

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**

Have you fallen in the last 12 months? ❑ Yes ❑ No **Were you injured from the fall? ❑ Yes ❑ No**

Have you completed any Advanced Directives? ❑ 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:** _____

FAMILY FOOT CENTER

PATIENT HIPAA ACKOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

ACKOWLEDGEMENT OF PRACTICE'S NOTICE OF PRIVACY PRACTICES:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of privacy Practices(NPP) and agree to its terms.

Printed Patient Name:_____

Signature of Patient/Guardian:_____

Date:_____