

Welcome to University Foot & Ankle Center

PATIENT INFORMATION FORM (PLEASE PRINT)

DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: ____ SEX: M F

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

HOME PHONE: _____

MAY WE LEAVE A MESSAGE?

YES NO

WORK PHONE: _____

YES NO

CELL PHONE: _____

YES NO

E-MAIL: _____

YES NO

PRIMARY LANGUAGE: _____

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: _____

PHARMACY: _____ LOCATION: _____

WE CAN GET YOUR MEDICINE HISTORY FROM YOUR PHARMACY. IS THIS OK? YES OR NO

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

___ NO ___ IF YES NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)? _____

RELATIONSHIP TO PATIENT _____ ADDRESS _____

CITY/STATE _____ ZIP _____ PHONE _____

WHO REFERRED YOU TO US: _____

NAME OF INSURED (IF DIFFERENT FROM NAME ON CARD): _____

DATE OF BIRTH OF INSURED: _____

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

NAME **DOSE** **HOW OFTEN DO YOU TAKE?**

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY **DATE**

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION **DATE**

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

Height: _____

Weight: _____

Race: _____

Ethnicity: _____

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE

CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

TOBACCO USE: NEVER QUIT - HOW LONG AGO? _____ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____

CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

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

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

REVISED: 4/23/2015

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE
 STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS
 OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____
 ANESTHESIA _____ FOODS _____ TAPE LATEX
 SHELLFISH IODINE OTHER _____ NONE KNOWN

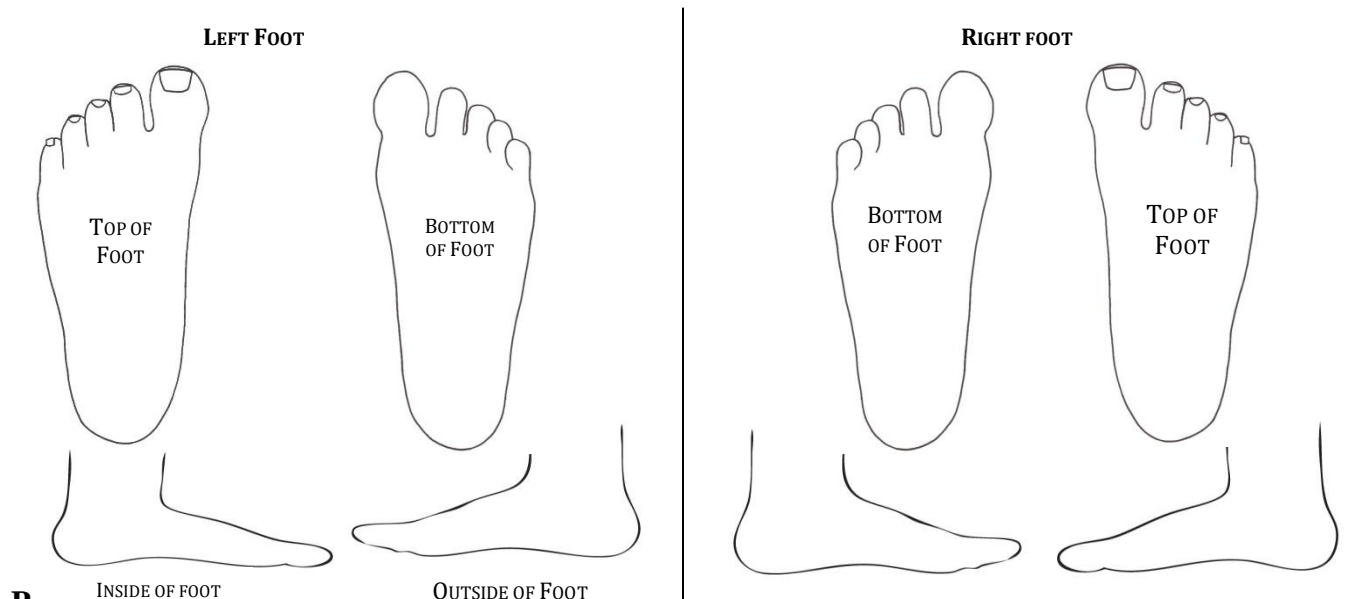
HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

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



P.
DATE OF BIRTH: ____/____/____
REVISED: 4/23/2015

OUTSIDE OF FOOT

INSIDE OF FOOT

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 RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

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? NO YES (DESCRIBE)

IF YES, WAS IT A WORK-RELATED INJURY? YES 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 and/or insurance information. I understand and agree that I will be responsible for payment of any and all services rendered by University Foot and Ankle Center, Dr. Jeffrey D. Poole or Dr. Caroline Gannon, and authorize the release of any diagnosis or records of treatment to my insurance(s) to support any medical claims made. I also authorize my insurance(s), Medicare/Medigap, to make payment directly to University Foot and Ankle Center, Dr. Jeffrey Poole or Dr. Caroline Gannon for services rendered. I certify the above information is true and correct. Should my account be forwarded to an outside collection agency, I agree to pay all collection fees and/or attorney fees incurred.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____
REVISED: 4/23/2015

SIGNATURE

DATE

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

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