Foot Specialists of Greater Cincinnati

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Birth Date ☐☐ ☐☐ ☐☐☐☐

☐ Single ☐ Married
☐ Widowed ☐ Other

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
☐ Declined

Primary Language
☐ English ☐ Spanish
☐ Other _____

Race
☐ Asian or Asian American ☐ Black or African American
☐ American Indian ☐ Caucasian / White ☐ Hawaiian / Pacific Is.
☐ Other ☐ Unknown / Unreported

Are you a student ?
☐ Full Time
☐ Part time
☐ Not a student

Birth Gender
☐ Female
☐ Male

Last Name _____ **First** _____ **MI** _____

Address : _____(city) _____ (state) _____ (zip) _____

Home Phone Area code ( )

Cell Phone Area code ( )

Work Phone Area code ( )

E-mail _____

Can we leave a message with any of phone numbers listed ? ☐ **Yes** ☐ **No**

Occupation: _____ Employer Name: _____

Is this a work or accident related injury ? ☐ **YES** ☐ **NO**
If "yes", please provide date and state where injury occurred: Date: _____ **State :** _____

Family Doctor _____ **phone number of physician:** ( ) _____ _____

Pharmacy _____ **Pharmacy phone** ( ) _____ _____

Last time family doctor was seen _____

Who referred you to our practice ? _____

Do you currently have a pain management contract ? ☐ **YES** ☐ **NO**

Please describe the reason for your visit today:

Has your problem been addressed by another physician previously ?
If so, please indicate type of practice that rendered the care

Emergency Contact Name
_____
Phone _____
Relationship _____

☐ Podiatrist ☐ Orthopedics
☐ Dermatology ☐ Rheumatologist
☐ Chiropractor ☐ Neurologist
☐ Other
☐ Chronic pain specialist

Date last seen _____

The above answers are true to the best of my knowledge

X _____ **X** _____

SIGNATURE ***DATE***

Name:
Date of Birth:

Medical History

Foot Specialists of Greater Cincinnati

Allergies: please check if you are allergic to any of the following:

☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Codeine ☐ Demerol ☐ Lidocaine
☐ Tylenol ☐ Aspirin ☐ Tetracycline ☐ Morphine ☐ Latex ☐ Other local anesthetics
☐ Adhesive tapes / bandages ☐ Clindamycin ☐ Cephalexin ☐ Iodine
☐ Metal(s) ☐ Azithromycin

☐ ***Allergies to other medications not listed*** :
☐ *I HAVE NO KNOWN DRUG ALLERGIES*

Height: _____

Weight: _____

Shoe Size: _____

Your Medications ☐ *I am not taking any medications at this time.*

1. 5. 9.

2. 6. 10.

3. 7. 11.

4. 8. 12.

Past Surgeries
(please list)

Do we have your permission to obtain your medication list from your pharmacy or other medical resources ? (circle one)

If "yes", then it is not necessary to provide a list of your medications

YES NO

Any complications from past surgery ? (*Please list*)

Social History: Please circle "yes" or "no" to questions below. Any question left unanswered will be considered a "no"

Do you smoke ? no yes - ___ Packs per day for ____ years Consume smokeless tobacco ? No YES
Did you ever smoke ? no yes- ___ Packs per day for ____ years (Quit smoking what year ? _____)
Do you drink alcohol ? no yes- approximately _____ wine beer liquor per week

History of Liver Disease ? No Yes ***History of Kidney Disease*** ? No Yes

Currently pregnant ?
YES **NO**

Check any problems pertaining to your health; boxes unmarked will be considered "no"

☐ Diabetes (if yes, how long ? _____
What was your Last A1c value ? _____
Insulin dependent ? Yes No
History of wounds / ulcers ? Yes No
☐ Any falls in last year ? If so, how many ? _____
☐ High Blood pressure
☐ Neuropathy (numbness / tingling to feet)
☐ Edema (swelling to feet or legs)
☐ Spinal problems / low back pain / Degenerative disk
☐ Mitral Valve prolapse
☐ Artificial Heart Valve
☐ Pace Maker / Defibrillator
☐ Bleeding tendencies - Are you on a Blood Thinner ?
☐ Sciatica / Lumbago
☐ Nerve Disorder(s)_____ Epilepsy ? _____
☐ Poor circulation to feet and / or Anemia
☐ History of blood clots or clotting problems
☐ History of Lyme Disease
☐ Headaches
☐ History of Joint replacement
☐ Alzheimer's / Dementia
☐ Asthma / breathing problems
☐ Skin Disorder _____
☐ Gout
☐ Arthritis (Degenerative)
☐ Tuberculosis
☐ Osteoporosis
☐ Cancer
☐ Heart Disease / Stroke
☐ Reflux disease or "GERD"
☐ Stomach ulcers
☐ Thyroid problem
☐ Psychiatric disorder
☐ Fibromyalgia
☐ Depression / Anxiety
☐ Parkinson's Disease
☐ Autoimmune Disease

Family History
Enter letter next to disease to indicate family member history

M = Mother **F**= Father
B = Brother **S** = Sister

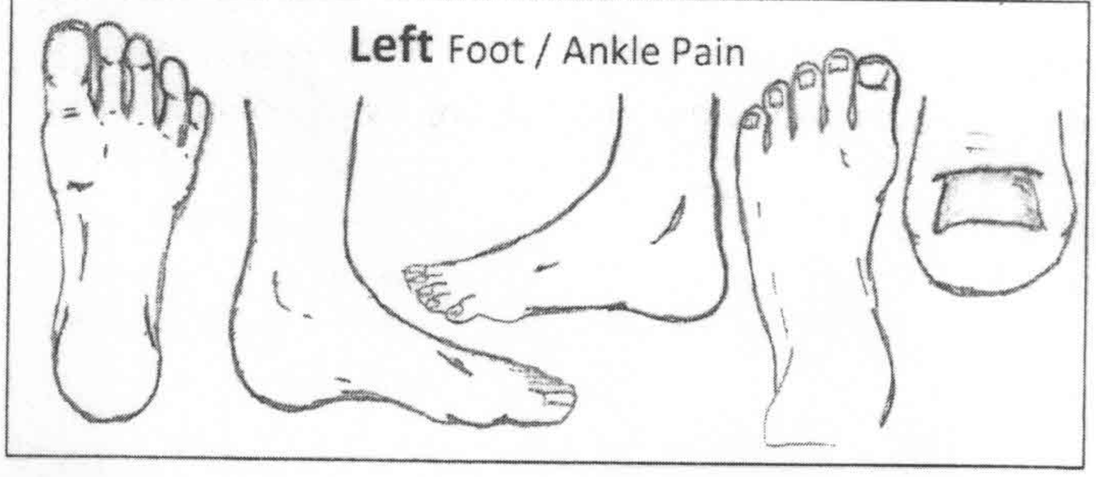
Diabetes _____
Heart Attack _____
↑ Blood pressure _____
Cancer_____
Arthritis _____
Stroke _____
Birth defects _____
Foot problem(s) _____

Autoimmune _____
(ie. Lupus, psoriasis, Rheumatoid arthritis)

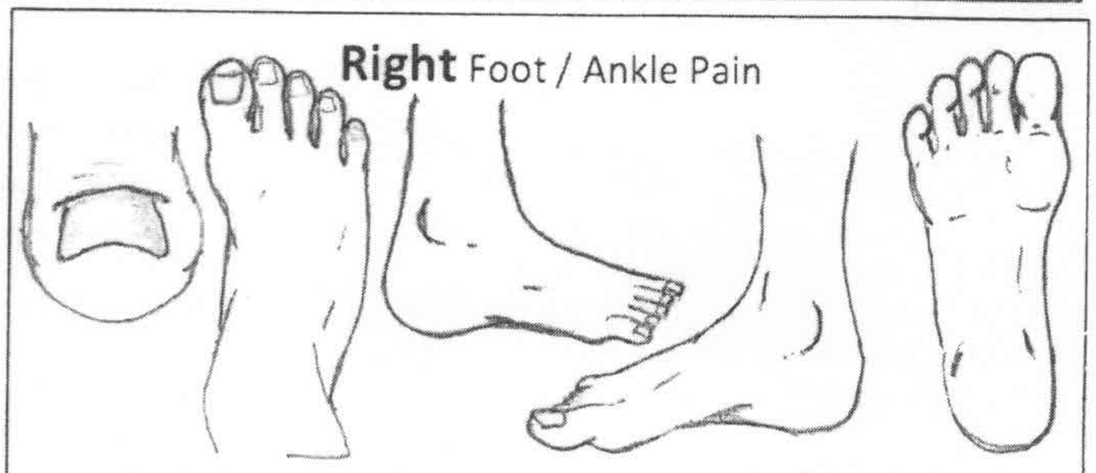
(O V E R)

Patient Name: Date of Birth:

Left Foot / Ankle Pain



Right Foot / Ankle Pain



Please indicate the location of your first problem on the drawing above with a number "**1**". Describe your problem below, including what you feel may have caused it.

_____

_____

Any treatments attempted ?

_____

_____

Please indicate the location of any second problem on the drawing above with a number "**2**". Describe your problem below, including what you feel may have caused it.

_____

_____

Any treatments attempted ?

_____

_____

Please mark the appropriate description of the problem.

Severity (1-10)	***Onset***	***Type of Pain***
☐ 1 (*least pain)*	☐ Days	☐ Stabbing
☐ 2	☐ Weeks	☐ Shooting
☐ 3	☐ Months	☐ Burning
☐ 4	☐ Years	☐ Throbbing
☐ 5 (*ie. Keeps you*	☐ Sudden	☐ Itching
☐ 6 *up at night*)	☐ Gradual	☐ Tingling
☐ 7		☐ Numbness
☐ 8		☐ Aching
☐ 9		☐ Gripping
☐ 10 (*worst pain, ie. Gun shot*)		☐ Pulling
		☐ Cramping
		☐ Electric
		☐ Pressure

Please mark the appropriate description of the problem.

Severity (1-10)	***Onset***	***Type of Pain***
☐ 1 (*least, ie. hangnail*)	☐ Days	☐ Stabbing
☐ 2	☐ Weeks	☐ Shooting
☐ 3	☐ Months	☐ Burning
☐ 4	☐ Years	☐ Throbbing
☐ 5 (*ie. Keeps you*	☐ Sudden	☐ Itching
☐ 6 *up at night*)	☐ Gradual	☐ Tingling
☐ 7		☐ Numbness
☐ 8		☐ Aching
☐ 9		☐ Gripping
☐ 10 (*worst pain, ie. Gun shot*)		☐ Pulling
		☐ Cramping
		☐ Electric
		☐ Pressure

The above information is true to the best of my knowledge

X _____ Date _____

Signature of Patient

***IF** form not completed by patient - Name of Individual filling out form* _____

Relationship to patient : (please circle one) Spouse Parent Legal guardian Family Friend Other

Doctor's Signature : _____ Date _____

Foot Specialists of Greater Cincinnati

Insurance Information

Name of person responsible for this bill_____ Phone Number _____

Relationship to patient / person being treated _____

Insurance Name _____ ID # _____ Group # _____

Primary insured _____

Insured Date of Birth _____ Insured social security # _____

Insured Employer's Name _____

Claims Address _____

Secondary Insurance Name _____ ID # _____ Group # _____

Claims Address _____

I give permission to Foot Specialists of Greater Cincinnati to administer treatment for my lower extremity conditions. I understand that I am financially responsible for all services rendered whether covered by insurance or not. I am also responsible for all fees if no referral is received for my care. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits directly to Foot Specialists of Greater Cincinnati. I understand the office appointment cancellation policy and fees involved if I choose to cancel an appointment without giving the office at least 24 hours notice. I understand that honest and complete answers to each question on these forms are important to my medical care and I have answered to the best of my ability. I have been informed that if I do not understand, I will ask the office staff for assistance.

X _____ date_____

Signature

Acknowledgement of Receipt of Notice of Privacy Practices

- I acknowledge that I was provided a copy of the Notice of Privacy Practice
- I have read (or had the opportunity to read, or have it read to me if so chose) and understand the Notice

_____

Patient Name (please print)

_____

Parent or Authorized Representative (if applicable)

X _____ DATE _____

Signature