Precision Foot and Ankle Clinic

PATIENT INFORMATION FORM

Patient Name:				Date of Birth:			
	Last Name	*First Name*	*MI*	Age:		Gender: ☐ M ☐ F	
Home Address:			City/State:			ZIP:	
Contact Details:							
Home Phone #:			Work Phone #:				
Cell Phone #:			Email Address:				
Primary Language:							
Race:			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 #:				
Pharmacy:			Location:				
Phone #:							
Is there a family member or other person you would like for us to share your medical information? ☐ Yes ☐ No							
If Yes, Name(s):							
Who is responsible for Payment?			Relationship:				
Address:			City/State:			ZIP:	
Phone:			Who referred you to us?				

INSURANCE INFORMATION

Primary Insurance Company name:					
Address:		City/State:		ZIP:	
Phone:					
Insured Name:		Date of Birth:		Employer:	
Contact #:		Group Number:			
Secondary Insurance Company name:					
Address:		City/State:		ZIP:	
Phone:					
Insured Name:		Date of Birth:		Employer:	
Contact #:		Group Number:			

Please list all medications you are currently taking (Including 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 INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse

Current Use – Type: _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ 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%

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind? _____

☐ Elderly or disabled family member ☐ Other _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily

Types of Exercise:

FAMILY HISTORY

Do you have a family history of:	YES	NO	Do you have a family history of:	YES	NO
Diabetes: Type 1 or Type 2	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Coronary Artery Disease	☐	☐
Hearth Disease	☐	☐	Thyroid Disease	☐	☐
High Blood Pressure	☐	☐	Rheumatoid Arthritis	☐	☐

YOUR MEDICAL HISTORY

Allergies:	☐ Medications; Please specify: _____	
	☐ Anesthesia;	☐ Food
	☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other: _____	
	☐ None known	

Have you ever had any of the following?

Conditions:	Y	N	Conditions:	Y	N	Conditions:	Y	N
Acid Reflux	☐	☐	Fibromyalgia	☐	☐	Neuropathy	☐	☐
Anemia	☐	☐	Gout	☐	☐	Open Sores	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Heart Disease/Failure	☐	☐	Polio	☐	☐
Back Trouble	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐
Bladder Infections	☐	☐	HIV+/AIDS	☐	☐	Sickle Cell Disease	☐	☐
Abnormal Bleeding	☐	☐	High Blood Pressure	☐	☐	Skin Disorder	☐	☐
Blood Clots	☐	☐	Kidney Disease	☐	☐	Sleep Apnea	☐	☐
Blood Transfusion	☐	☐	Liver Disease	☐	☐	Stomach Ulcers	☐	☐
Bronchitis/Emphysema	☐	☐	Low Blood Pressure	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Migraine Headaches	☐	☐	Thyroid Disease	☐	☐
Diabetes: Type 1 or Type 2 (circle)	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐

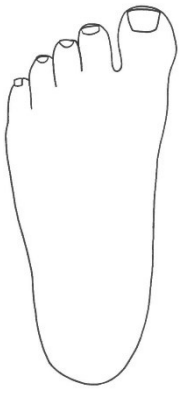
Other Conditions:

CURRENT PROBLEM

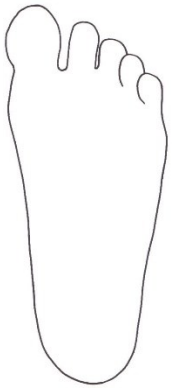
What specific problem brings you to our clinic today? _____

Where is the pain/problem located? Please mark the pictures below.

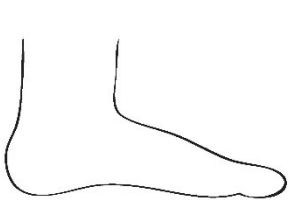
LEFT FOOT



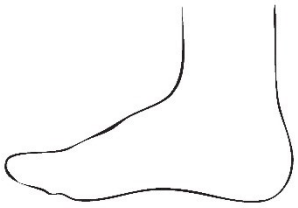
TOP OF FOOT



BOTTOM OF FOOT

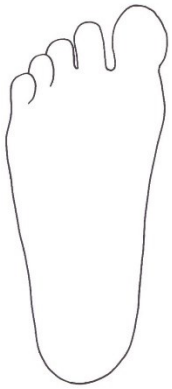


INSIDE OF FOOT



OUTSIDE OF FOOT

RIGHT FOOT



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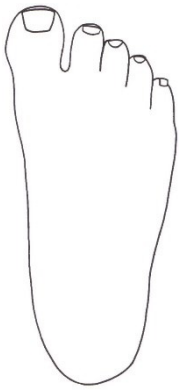

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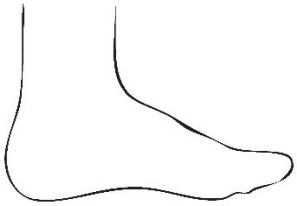
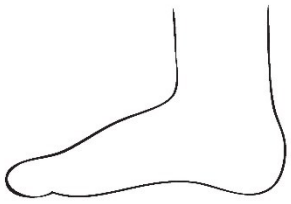


OUTSIDE OF FOOT



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
How would you rate your pain on a scale from 0 to 10?	
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
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 shoes ☐ Running Others, please specify: _____
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, please describe: _____ ☐ No
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.

_____ _____

Print name of patient, parent or guardian Signature of doctor

_____ _____

If other than patient, relationship to patient Date

_____

Signature

_____

Date