

Name: _____ DOB: _____ Chart Number: _____
 Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____
 E-mail: _____ Spouse/Partner Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____ Work #: _____
 Pharmacy: _____ Phone: _____
 Primary Care Physician: _____ Phone: _____ Date Last Seen: _____
 Address: _____
 Employer: _____ Phone: _____
 Address: _____

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: _____
 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: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____
 What is the reason for your visit today? _____

 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

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History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues	
<input type="checkbox"/> Liver	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Blood clot	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> Skin disorders (specify) _____	
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____				
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> other (specify) _____				

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

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? Yes, I do the following regular exercise: _____

No, I do not exercise regularly

Family History

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

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

Review of Systems (Please check the box if you currently have any of these symptoms)

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency	
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> constipation	<input type="checkbox"/> increase appetite	<input type="checkbox"/> decrease appetite
Integumentary	<input type="checkbox"/> athletes foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			

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Practice: HOUSLANGER & KASSNOVE PODIATRISTS, PLLC Chart Number:

Name: _____ **Date of birth:** _____

Race: _____ I prefer not to answer I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ I prefer not to answer I do not know

Preferred Language: **English** I prefer not to answer

Privacy Information Preferences

Were you offered a copy of the HIPAA Privacy Practice Notice? Yes No

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 answering machine? Yes No

Will you allow internet based delivery reminders like email? Yes No

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

Smoking Status

Current Every Day Smoker

Current Some Day Smoker

Former Smoker

Never Smoker

I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____

Weight: _____

I prefer not to answer I do not know

Current Medications None

I take these prescription or over the counter medications:

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Use the back of this form if more room is needed

Allergy	Reaction
<input type="checkbox"/> No Known Allergies	
<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Shellfish	_____
<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Tape	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Betadine (iodine)	_____
<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Tylenol™	_____
<input type="checkbox"/> Ibuprofen	_____
<input type="checkbox"/> Codeine	_____
<input type="checkbox"/> Other (specify) _____	_____

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