PATIENT NAME ❑ Male ❑ Female AGE BIRTHDATE

ADDRESS CITY/STATE ZIP

PRIMARY PHONE #1 PHONE # 2 EMAIL ADDRESS

PREFERRED METHOD OF CONTACT: ❑ PHONE ❑ EMAIL ❑ MAIL

❑ Single ❑ Divorced ❑ Widow ❑ Married: SPOUSE/PARTNER's NAME_____

PRIMARY LANGUAGE ETHNICITY

PERSON TO NOTIFY IN CASE OF EMERGENCY PHONE

How did you choose our office? ❑ Family/Friend ❑ Internet ❑ Phone Book ❑ Insurance Directory

❑ Other (explain)_____ ❑ Referred by Dr. _____

PATIENT'S EMPLOYER OCCUPATION

PRIMARY CARE PHYSICIAN DATE OF LAST VISIT

PHARMACY

INSURANCE #1 POLICY #

SPONSOR MEMBER SPONSOR BIRTH DATE

INSURANCE #2 POLICY #

SPONSOR MEMBER SPONOSOR BIRTH DATE

Is there another person responsible for your bill? If yes, please complete the following:

NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ PHONE _____

CITY/STATE/ZIP/_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

Name_____Height_____Weight_____Shoe Size_____

Current Medications ☐ None or List:_____

Headaches	☐ Yes	☐ No	Fever, chills or night sweats	☐ Yes	☐ No
Weight gain or loss	☐ Yes	☐ No	Blurred vision	☐ Yes	☐ No
Partial blindness	☐ Yes	☐ No	Hearing loss	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No	Nose or sinus problems	☐ Yes	☐ No
Mouth or throat problems	☐ Yes	☐ No	Pain or pressure in chest	☐ Yes	☐ No
Palpitations (fluttery heart)	☐ Yes	☐ No	Short of breath	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Nausea or vomiting	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No	Weakness in arm or leg	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No	Swollen feet or ankle(s)	☐ Yes	☐ No
Low back pain	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Infection	☐ Yes	☐ No	Dizzy	☐ Yes	☐ No
Balance problems	☐ Yes	☐ No	Tingling, burning, numbness	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Thirsty all the time	☐ Yes	☐ No
Hungry all the time	☐ Yes	☐ No	Pain in calf	☐ Yes	☐ No
Swollen lymph nodes	☐ Yes	☐ No	Other conditions, surgeries or serious injuries:		

Females: Are you pregnant? ☐ Yes ☐ No _____
Breast Feeding ☐ Yes ☐ No

Medical History

☐ AIDS/HIV Positive(_____# of years)	☐ Anemia – Type:_____	☐ Arthritis - Type: _____
☐ Asthma	☐ Bleeding Disorder	☐ Cancer
☐ Circulation problem	☐ Gout	☐ Epilepsy
☐ Diabetes Type ___ for ___years	☐ Heart Disease	☐ Drug/Alcohol Dependency
☐ Hepatitis – Type _____	☐ High Blood Pressure	☐ Kidney Disease
☐ Liver Disease:_____	☐ Lung Disease	☐ Mitral Valve Prolapse
☐ Neurologic Disorder:_____	☐ Stomach Ulcers	☐ Stroke
☐ Thyroid Condition	☐ Vascular Grafts	☐ Heart Valves
☐ Pacemaker	☐ Metals/Pins/Screws/Plates	☐ Artificial Joint:_____

☐ Other conditions, surgeries or serious injuries_____

☐ No known allergies
☐ Aspirin ☐ Cortisone ☐ Tape ☐ Narcotics ☐ Iodine/betadine ☐ Local Anesthetic ☐ Penicillin
☐ Anti-Inflammatories (Motrin/Tylenol) ☐ Sulphur ☐ Other_____

Do You Smoke? ☐ Never ☐ Yes ☐ Previously ___Packs/Day___# of Years
Recreational Drugs? ☐ No ☐ Yes, List _____
Drink Alcoholic Beverages? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Indicate Mother (M) Father (F) Brother (B) Sister (S) with the following conditions:

☐ Diabetes M☐F☐B☐S☐	☐ Arthritis M☐F☐B☐S☐	☐ Heart Attack M☐F☐B☐S☐	
☐ Gout M☐F☐B☐S☐	☐ Bunion M☐F☐B☐S☐		
☐ Stroke M☐F☐B☐S☐			

What do you do for exercise?_____

How much time do you spend doing it per week?_____

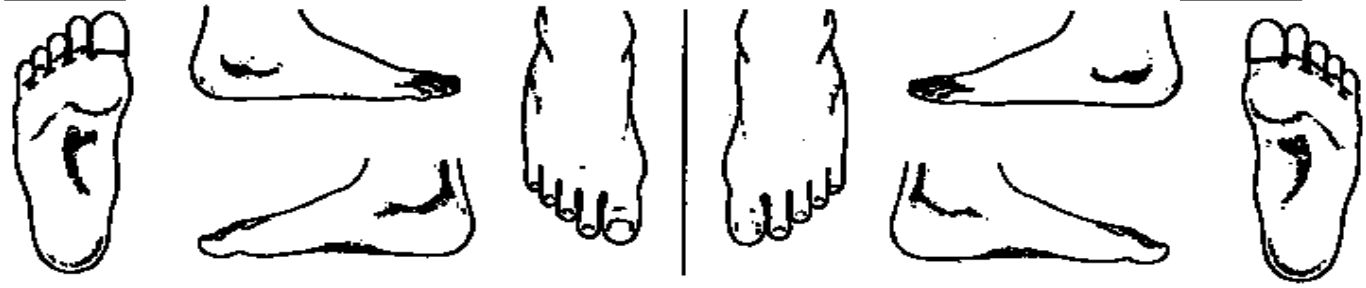
FOOTWEAR: ☐ I go barefoot in the house ☐ I wear shoes or slippers in the house.
Most other times I wear: ☐ work boots ☐ dress shoes ☐ heels ☐ athletic shoes ☐ slippers

_____ _____
Patient Signature Date

Patient Name_____Age_____Date_____

Reason for Visit _____

Right ☐ Mark Location of Pain or Problem Left ☐



Does your visit today have anything to do with a work-related injury? ❑ Yes ❑ No

Describe your pain:
❑ Shooting ❑ Burning ❑ Throbbing ❑ Sharp ❑ Aching
❑ Tender ❑ Numb ❑ Itching ❑ Dull ❑ Tingling ❑ Other_____

Check Pain Level: ☐ 0 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ No Pain ☐ Mild ☐ Moderate ☐ Severe ☐ Worst Ever

How long has the problem/pain existed?_____
Problem is: ❑ Constant ❑ Getting Worse ❑ Getting Better ❑ Intermittent

It happened: ❑ At Home ❑ At Work ❑ During Sports
❑ Walking ❑ I Don't Know ❑ Other _____

Previous treatment
or self care for this problem:

Practice Requirements – HIPPA COMPLIANCE - This Notice is in effect as of 4/15/03
Aloha Foot Centers:
a) Is required by federal law to maintain the privacy of your Personal History Information (PHI) and provide you with this privacy notice detailing the practice's legal duties and privacy practices with respect to your PHI.
b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restriction on the use or release of your PHI than that which is provided for under federal law.
c) Is required to abide by the terms of this privacy notice.
d) Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your PHI that it maintains.
e) Will distribute any revised privacy notice to you prior to implementation.
f) Will not retaliate against you for filing a complaint.

I acknowledge I have read this notice, understand the information and agree to its terms. I can have a copy of this notice at any time. I certify that the above information is complete and correct to the best of my knowledge. I give permission to Aloha Foot Centers to file all medical claims on my behalf. I request that payment of authorized benefits be made to Aloha Foot Centers on my behalf for medical services rendered to me. I consent to have my photo taken for my medical records.

_____
Patient Signature/Date

Please fax to: Aloha Foot Centers
(808) 263-6004