Hilliard Family PODIATRY, LLC.

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| **PATIENT FULL NAME:** DATE OF BIRTH: GENDER: FEMALE MALE |
| SOC SEC # MARITAL STATUS: MARRIED SINGLE PARTNERED DIVORCED WIDOWED  .  . |
| RACE WHITE PACIFIC ISLANDER OTHER ETHNICITY: LANGUAGE:  .  .  .  AMERICAN INDIAN ASIAN BLACK/AFRICAN AMERICAN HISPANIC NON-HISPANIC  .  .  .  .  . |
| ADDRESS: CITY: STATE: ZIP: |
| PRIMARY PHONE: **TYPE: H/W/C** SECONDARY PHONE**:** **TYPE: H/W/C** OKAY TO **LEAVE MESSAGE: YES NO**  OKAY TO **TEXT:** **YES** **NO** |
| E-MAIL ADDRESS: |
| **EMPLOYER:** PHONE: OCCUPATION: |
| **RESPONSIBLE PARTY: SELF SPOUSE PARENT OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ADDRESS: CITY: STATE: ZIP: |
| DOB: SOC SEC #: PRIMARY PHONE #: |
| **EMERGENCY CONTACT:** RELATIONSHIP: PHONE #: |

**INSURANCE INFORMATION**

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| Primary Insurance: SUBSCRIBER: DOB: |
| Secondary Insurance: SUBSCRIBER: DOB: |

**CONTINUITY OF CARE**

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| **PRIMARY CARE PHYSICIAN:** PHONE: DATE LAST SEEN: |
| **PHARMACY:** PHONE: ZIP: |
| **REFERAL:**  DR.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT INTERNET INSURANCE ADVERTISMENT OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY**

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| DO YOU SMOKE? NO PAST USE YES HOW MANY PACKS PER DAY? \_\_\_\_ FOR HOW LONG? \_\_\_\_ | | |
| DO YOU USE DRUGS? NO YES PAST USER | | |
| DO YOU DRINK ALCOHOL? NO YES ( 1-2 DRINKS/MONTH 1-2 DRINKS/WEEK 2-3 DRINKS/WEEK 3+/WEEK) | | |
| EXERCISE? NEVER OCCASIONALLY WEEKLY DAILY | | |
| **HEIGHT** | **WEIGHT** | **SHOE SIZE** |

**MEDICAL HISTORY**

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| **DO YOU HAVE DIABETES: YES NO HOW LONG?** |
| HOW DO YOU CONTROL YOUR DIABETES? DIET INSULIN OTHER MEDICATION |
| WHAT WAS YOUR LAST BLOOD SUGAR LEVEL OR A1C? |

**MEDICAL HISTORY**

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| --- | --- | --- | --- |
| AIDS/HIV | SELF FAMILY | HIGH CHOLESTEROL | SELF FAMILY |
| ANEMIA | SELF FAMILY | HYPERTENSION | SELF FAMILY |
| ANXIETY | SELF FAMILY | KIDNEY PROBLEMS / DISEASE | SELF FAMILY |
| ARTHRITIS (GENERAL) | SELF FAMILY | MENTAL DISORDER | SELF FAMILY |
| ASTHMA | SELF FAMILY | OPEN SORES | SELF FAMILY |
| BACK PAIN | SELF FAMILY | OSTEOPOROSIS | SELF FAMILY |
| BLEEDING DISORDER | SELF FAMILY | POOR CIRCULATION | SELF FAMILY |
| BLOOD CLOTS | SELF FAMILY | RHEUMATOID ARTHRITIS | SELF FAMILY |
| CANCER | SELF FAMILY | SLEEP APNEA | SELF FAMILY |
| DEPRESSION | SELF FAMILY | STD / STI | SELF FAMILY |
| EPILEPSY / SEIZURES | SELF FAMILY | STOMACH ULCERS | SELF FAMILY |
| FIBROMYALGIA | SELF FAMILY | STROKE | SELF FAMILY |
| GOUT | SELF FAMILY | THYROID / HIGH / LOW | SELF FAMILY |
| HEADACHES | SELF FAMILY | TUBERCULOSIS ACTIVE / NON | SELF FAMILY |
| HEARING PROBLEMS | SELF FAMILY | VEIN DISORDER | SELF FAMILY |
| HEART DISEASE | SELF FAMILY | VISION PROBLEMS | SELF FAMILY |
| HEPATITIS ( A / B / C ) | SELF FAMILY |  |  |
| **PLEASE LIST OTHERS:** |  |  |  |
| **HAVE YOU HAD ANY OF THE FOLLOWING:** CHICKEN POX MEASLES MUMPS POLIO | | | |

**ALLERGIES**

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| **NAME** | **REACTION** | **NAME** | **REACTION** | **NAME** | **REACTION** |
| \_\_\_ASPIRIN |  | \_\_\_NSAIDS |  | \_\_\_PENICILLIN |  |
| \_\_\_CODEINE |  | \_\_\_DEMEROL |  | \_\_\_ANESTHETICS |  |
| \_\_\_CORTISONE |  | \_\_\_SULFA |  | \_\_\_LATEX |  |
| \_\_\_IODINE/  SHELLFISH |  | \_\_\_TAPE/  ADHESIVES |  | \_\_\_IV CONTRAST  (DYE) |  |
| LIST ANY OTHERS: | | | | | |
| ENVIRONMENTAL / FOOD: **NO KNOWN DRUG ALLERGIES** | | | | | |

**MEDICATION LIST: Do we have permission to electronically obtain your medication list? \_\_\_ Yes \_\_\_ NO**

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| **NAME OF MEDICATION** | **REASON FOR MEDICATION** |
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**PAST DIAGNOSTIC TESTING**

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| **(MRI / X-RAY / CT) OF FOOT/ANKLE** | **DATE** | **WHERE WAS THE TEST PERFORMED** |
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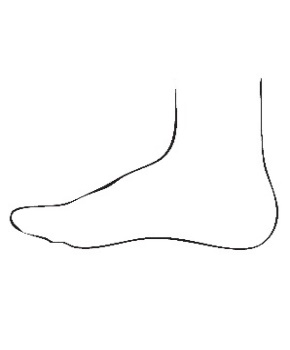
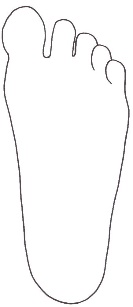
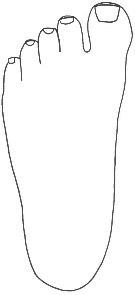
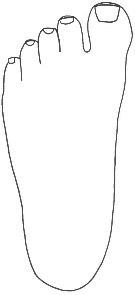
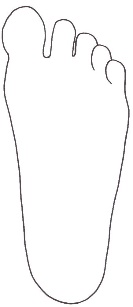
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| **HISTORY OF ANY GENERAL SURGERIES: DATE/YEAR:** |
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| **HISTORY OF ANY FOOT SURGERIES: DATE/YEAR:** |
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| **REASON FOR VISIT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LENGTH OF CONDITION: \_\_\_\_\_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS  LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CHARACTERISTICS OF PAIN: ACHING NUMB BURNING DULL SHOOTING SHARP STABBING ITCHING DEEP SUPERFICIAL |
| PAIN LEVEL: **0 1 2 3 4 5 6 7 8 9 10** |
| PAST TREATMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PREVIOUS DOCTORS SEEN FOR THIS CONDITION: |
| **WHAT HAS HELPED SYMPTOMS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **WHAT MAKES SYMPTOMS WORSE:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CIRCLE PROBLEMATIC AREAS**

 **LEFT FOOT** **RIGHT FOOT**

******** TOP BOTTOM BOTTOM TOP

INSIDE OUTSIDE OUTSIDE INSIDE

I hereby give permission for Hilliard Family Podiatry to render the proposed podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim and I request payment of insurance benefit due to Hilliard Family Podiatry to be paid directly to Hilliard Family Podiatry. I hereby give my permission for Hilliard Family Podiatry to forward any pertinent medical information to my primary of referring physicians for continuity of care. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either me or my insurance company in writing. The above information is true and I will notify Hilliard Family Podiatry of any changed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_