Hilliard Family PODIATRY, LLC.

PATIENT FULL NAME:	DATE OF BIRTH:	GENDER: ☐ FEMALE ☐ MALE
SOC SEC #	MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ PARTNERED ☐ DIVORCED ☐ WIDOWED	
RACE ☐ WHITE ☐ PACIFIC ISLANDER ☐ OTHER ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN	ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC	LANGUAGE:
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

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

CONTINUITY OF CARE

PRIMARY CARE PHYSICIAN:	PHONE:	DATE LAST SEEN:
PHARMACY:	PHONE:	ZIP:

REFERAL:

☐ DR._____ ☐ PATIENT ☐ INTERNET ☐ INSURANCE ☐ ADVERTISMENT ☐ OTHER:_____

SOCIAL HISTORY

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+ DRINKS/WEEK) ☐		
EXERCISE? ☐ NEVER ☐ OCCASIONALLY ☐ WEEKLY ☐ DAILY		
HEIGHT	**WEIGHT**	**SHOE SIZE**

MEDICAL HISTORY

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

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

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

NAME OF MEDICATION	**REASON FOR MEDICATION**

PAST DIAGNOSTIC TESTING

(MRI / X-RAY / CT) OF FOOT/ANKLE	**DATE**	**WHERE WAS THE TEST PERFORMED**

HISTORY OF ANY <u>GENERAL</u> SURGERIES:	**DATE/YEAR:**

HISTORY OF ANY FOOT SURGERIES:	**DATE/YEAR:**

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:

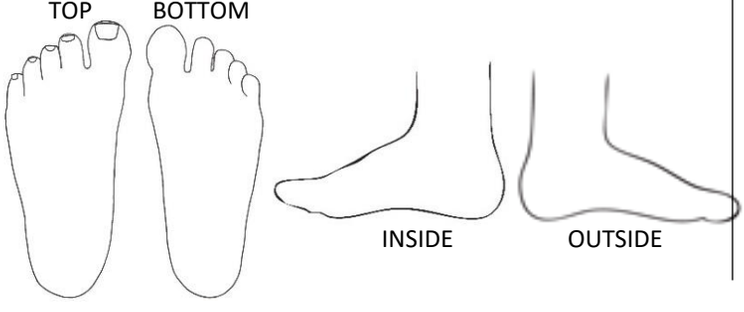
_____

WHAT MAKES SYMPTOMS WORSE:

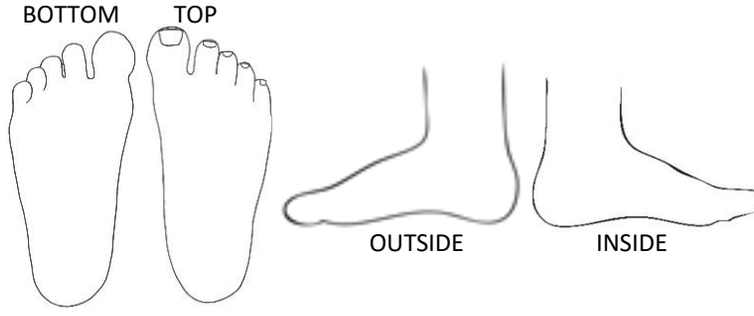
_____

CIRCLE PROBLEMATIC AREAS

LEFT FOOT



RIGHT FOOT



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: _____