Dr. Ned M. Ramadan, DPM

234 Broad Street, Milford CT

Name: _____

Podiatry Issues: (Why are you being seen?): _____

What is your current pain level? Please circle number below.

Have you been hospitalized in the last 2 years? Yes☐ No☐ (If yes, please describe) _____

Past surgical history: (Type of Surgery and date)

_____
_____
_____

Medications: (Name only needed)

_____
_____
_____

Height: _____
Weight: _____
Shoe size: _____

If you are a diabetic what was your last hemoglobin A1C value? _____

Pharmacy Name: _____ Address: _____ City & State _____

Allergies: (check only ones that apply) - ☐ None

☐ Aspirin ☐ Sulfa ☐ Latex ☐ Codeine ☐ Novocain/lidocaine ☐ Penicillin
☐ Iodine ☐ Adhesive tape Other _____

Illnesses and chronic conditions: Do you or any of your family member(s) have any of the following:

	Patient	Father	Mother	Grandparent	Sibling
Diabetes					
Neurologic					
Foot deformities					
Toenail problems					
Bunion(s)					
Hammer toe(s)					
DECEASED	■				

If your family history is unknown please check here: ☐

Do you have any of the following conditions?

	Yes	No	Specify
Vision Problems			
High Blood Pressure			
Heart Problems			
Lung Problems			
Liver Problems			
Diabetes			
Kidney Problems			
Back Problems			
Joint Problems			
Skin Disorders			
Stroke			
Other Nerve Disorders			
Psychiatric Diagnosis			
Anemia			

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Social History:

Have you ever smoked? Yes☐ No☐ If yes, when did you quit? _____ When did you start smoking? _____
Do you currently smoke? Yes☐ No☐ How many packs per day? _____ How many years? _____
Are you ready to quit? Yes☐ No☐

Have you had an alcoholic beverage in the last 12 months? Yes☐ No☐
How often do you drink: weekly____ monthly_____ How many drinks per day? _____

Have you had 2 or more falls in the last year? Yes☐ No☐
Describe any injury: _____
Have you had 1 fall with injury? Yes☐ No☐
Describe the injury: _____

Your preferred language is: English☐ Spanish☐ French☐ Italian☐ Chinese☐ Portuguese☐ Other☐
Race/Ethnicity: Caucasian (White) ☐ African American/Black☐ Hispanic☐ Indian☐ Asian☐ Other☐

Are you employed? Yes☐ No☐ Place of employment: _____ Occupation: _____
Does your job require you to stand for long periods of time? Yes☐ No☐ How Long? _____
With whom do you live? _____

Who referred you to our office: _____

Is this office visit due to any of the following:

Injured while on the job: YES ☐ NO ☐ **Auto Accident**: YES ☐ NO ☐ **Personal Injury:** YES ☐ NO ☐b
If you answered YES to any of the above, please ask the receptionist for a Worker's Compensation Form to complete.

IS THE PATIENT RESPONSIBLE FOR PAYMENT? YES ____ NO____

IF NO, PLEASE COMPLETE:

Name of Responsible Party: _____ Relationship: _____
Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____
I also authorize treatment to myself and/or my child (or dependent if you are the guardian).

IN CASE OF EMERGENCY PLEASE CONTACT:
Name: _____ Phone: _____ Relationship: _____

•I authorize Reconstructive Foot Surgeon, LLC to release all information for filing insurance claim(s).
•If my insurance requires a written referral from my PCP, it is my responsibility to obtain that referral.
•I am responsible for payment if a referral is not obtained.
•I authorize Reconstructive Foot Surgeon, LLC to obtain medical information from other physicians for the continuity of my care.
•I have received a copy of the financial policy for Reconstructive Foot Surgeon, LLC

I acknowledge that I have been offered a copy of the Privacy Practice notice made available to me in the office or online at nedramadan.com under privacy-policy forms to read and review.

SIGNATURE: _____ DATE: _____
PRINT NAME: _____
Name of person completing this form: _____
Relationship: (if other than patient) _____