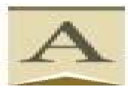 Advanced Foot and Ankle Surgeons, Inc.

Dr__ S__ B__

DATE: _____/_____/_____ AGE: _____________

PATIENT NAME: ____________________________________ DATE OF BIRTH _____/_____/_______

SEX: M F HOME ADDRESS: ____

CITY/STATE: _____________________ ZIP: _____________ SSN: ___________________

Select Yes or No Below where we can leave messages regarding your care, confidential information & appointments

HOME PHONE #: (_____) ______- ____________ YES NO E-MAIL: _____________________ YES NO

CELL PHONE#: (_____) ______ - ____________ YES NO WORK PHONE#: (_____) ______ - ________ YES NO

Preferred Spoken Language:__________ Ethnicity:(select one) Non Hispanic___ Hispanic___ Not Specified ____

Race: (select one) African/African American ___ Asian/Asian American ____ Caucasian/European America___ Native American/Native Alaskan____ Native Hawaiian/Other Pacific Islander____ Other Race_______

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _________________________ RELATIONSHIP: _____________ PHONE #: _______________

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE US TO SHARE YOUR MEDICAL INFORMATION?

____ NO _____YES NAME (S) ____

IF UNDER 18 YEARS OLD –

Mom's Name: ______________________________ Dad's Name: ______________________________________

Mom's Address: _______________________________City: ___________________ State/Zip: _________________

Dad's Address: ________________________________ City: ___________________State/Zip: _________________

WHO IS RESPONSIBLE FOR PAYMENT: _____________________ RELATIONSHIP TO PATIENT? ___________

ADDRESS: _________________ CITY/STATE: ______________ ZIP: ________ PHONE: ______________

SOCIAL SECURITY #: ____________________________

INSURANCE INFORMATION: **PRIMARY INSURANCE**: ____

INSURED NAME: _____________________________________ DATE OF BIRTH: _______________________________

MEMBER ID #: __________________________ GROUP #: __________________________________

SECONDARY INSURURANCE: ____

INSURED NAME: _____________________________________ DATE OF BIRTH: _______________________________

MEMBER ID#: _______________________________ GROUP #: ___________________________________

*** IF YOUR CURRENT PROBLEM IS DUE TO A WORK RELATED INJURY PLEASE NOTIFY RECEPTIONIST SO THAT YOU CAN FILL OUT WORK COMPENSATION FORM; IT IS YOUR RESPONSIBILITY TO PROVIDE US THE NECESSARY INFORMATION REGARDING YOUR CLAIM.

IS YOUR FOOT/ANKLE PROBLEM DUE TO A WORK INJURY? NO ___ Yes ___

PATIENT NAME: ______________________________

I am not taking any medication: _____ I provided a list of my medications: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME: DOSE: HOW OFTEN DO YOU TAKE?

____

____

____

____

ALLERGIES: I have no known allergies to medication: _________

Check if you have allergies to the following and state your reaction:

Other: ____________/____________ Penicillin ________/Reaction_________________

Codeine ___/___________ Sulfa _______/____________ Iodine/Shell Fish______ _/_____________

Latex____/_____________ Novocain/Local Anesthetic_______/___________ Adhesive Tape ________/_________

Height: _____ Weight: _____ Shoe Size: _____ Pharmacy & Location: ____________________________________

List your Primary Care Doctor's First AND Last Name ? _____________________________ City: ___________________

Last Date You Were Seen by Your Doctor: ___________________ Phone #: ____________________________________

PLEASE LIST ALL PRIOR SURGERIES:

Date/Year Type Surgeon Location

____

____

____

____

____

SOCIAL HISTORY Preferred Spoken Language: __________

Marital History: Single ___ Married___ Divorced ___ Separated __ Partnered__ Widowed ___

USE OF ALCOHOL: No __ Yes_____ If Yes, What, how much and how often? _____________________________

Tobacco Use: No ___ Yes ____ If Yes, 0-100 lifetime 0-3/day 1pack/day 1-2 packs/day 2 + packs/day

If you quit, when did you quit and how long did you use tobacco products: __________________________

Use of Recreational Drugs: No____ Yes ____ What kind/how often? ______________________________

EMPLOYER: _____________________________________ OCCUPATION: ___________________________

How much are you on your feet at work (circle one)? 10% 25% 50% 75% 100%

EXERCISE: NEVER ___ RARE ___ OCCASIONAL ___ WEEKLY ___ SEVERAL TIMES/WK ___ DAILY ___

TYPE OF EXERCISE: ____

HOW WERE YOU REFERRED TO OUR OFFICE? Patient __ Newspaper __ Friend __ Insurance __ Internet __

Family __ Yellow Book __ Home Pages __ Doctor referral, Dr. ___________________ Other_____________

PATIENT NAME: ______________________

YOUR MEDICAL HISTORY Do You or Your Immediate Family Have Any of the Following?

You	Family		You	Family		You	Family	
___	___	ACID REFLUX	___	___	FIBROMYALGIA	___	___	NEUROPATHY
___	___	ANEMIA	___	___	GOUT	___	___	OPEN SORES
___	___	ARTHRITIS	___	___	HEART ATTACK	___	___	PNEUMONIA
___	___	ASTHMA	___	___	HEART DISEASE/FAILURE	___	___	SKIN DISORDER
___	___	BACK TROUBLE	___	___	HEPATITIS	___	___	SLEEP APNEA
___	___	BLOOD CLOTS	___	___	HIV +/AIDS	___	___	STOMACH ULCERS
___	___	CANCER	___	___	HIGH BLOOD PRES	___	___	STROKE
___	___	DIABETES	___	___	KIDNEY DISEASE	___	___	THYROID DISEASE
___	___	FOOT PAIN	___	___	LIVER DISEASE	___	___	NUMBNESS/TINGLING IN FEET

Other Medical Conditions Not Listed Above: ____

DIABETICS: What doctor manages your diabetic medication? ____________________________________

Are you taking insulin: No ____ Yes ___ How many years have you been a diabetic: ____________

Last HgA1c (hemoglobin A1c):___ Lowest blood sugar level in past month: ____ Highest sugar level in past month: ____

Have you ever had an foot/leg ulcer ? No __ Yes __ if yes, which foot and where: ______________________

How long did you have your ulcer: ____

Do you have an ulcer now: No __ Yes __ If Yes, describe where, the duration, and treatments: _______________

____

Have you had an amputation of part or all of your foot? No ___ Yes ____ If yes, describe:__________________

____

Have you ever been told you had poor circulation to your feet: No __ Yes ___ if yes, describe: ______________

Have you ever been told you had poor sensation to your feet: No __ Yes___ if yes, describe:_______________

Have you ever had Diabetic Shoes with inserts: No __ Yes ___ If yes, where & when did you get your last pair________

WHAT SPECIFIC PROBLEM BRINGS YOU TO THE OFFICE TODAY? List Location and Give a Brief Description.

PROBLEM #1: ____

LOCATION? ________________________WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM? ____________________

WHAT TREATMENT HAVE YOU HAD? ____

PROBLEM #2: ____

LOCATION? ________________________WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM? ____________________

WHAT TREATMENT HAVE YOU HAD? ____

PROBLEM #3: ____

LOCATION? ________________________WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM? ____________________

WHAT TREATMENT HAVE YOU HAD? ____

WERE ANY OF THESE PROBLEMS CAUSED BY AN INJURY? NO ___ YES___ DESCRIBE____________________________

IS YOUR FOOT/ANKLE PROBLEM DUE TO A WORK INJURY? NO ___ Yes ___

*** IF YOUR CURRENT PROBLEM IS DUE TO A WORK RELATED INJURY PLEASE NOTIFY RECEPTIONIST SO THAT YOU CAN FILL OUT WORK COMPENSATION FORM; IT IS YOUR RESPONSIBILITY TO PROVIDE US THE NECESSARY INFORMATION REGARDING YOUR CLAIM.