DocMartins
FOOT & ANKLE CLINICS

Patient Information Form

Date: ___/____/____
Patient Name: _____ _____ ___ DOB: ___/___/___ Age: ___ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

Phone #: (____) ____-_____ Cell Phone #: (____) ____-_____ SSN: _____

Emergency Contact: _____ PHONE #: (____) ____-_____Pharmacy: _____

Employer: _____ Occupation: _____

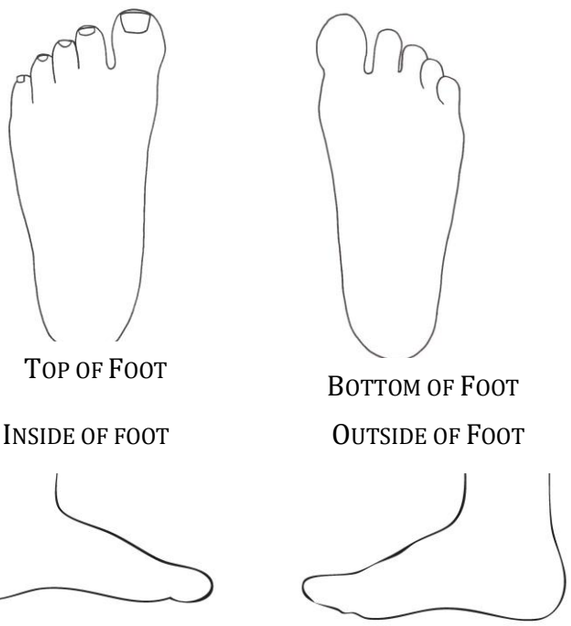
Primary Care Physician? _____
Who Referred You To Us? _____

Current Problem

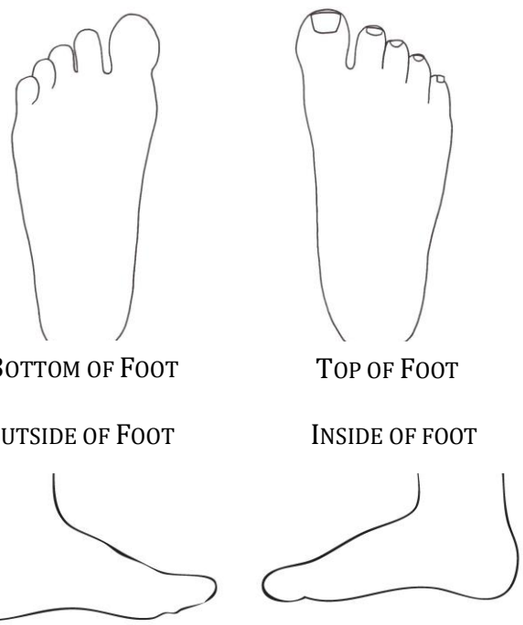
What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot



Right foot



How long ago did this problem first start? _____ Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develops overtime

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe ☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

Was this problem caused by an injury? ☐ Yes (describe) _____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

Are you or your Primary Care Doctor on **MyChart**? ☐ Yes (if skip to signature) ☐ No

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS): (IF YOU HAVE A LIST SUPPLY IT OR ITS ON EPIC INDICATE IT CAN BE PRINTED)

NAME DOSE HOW OFTEN DO YOU TAKE?

_____

_____

_____

_____

PAST MEDICAL HISTORY -CONDITIONS

_____

_____

_____

_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

_____

_____

_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____ _____

_____ _____

_____ _____

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA ☐ FOODS ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ UNKNOWN

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE ☐ RARE ☐ OCCASIONAL

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐ OTHER _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

ACKNOWLEDGE OF RECIEPT

AND

NOTICE OF PRIVACY POLICY

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE PRACTICE POLICY AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE TO) AND UNDERSTAND THE NOTICE.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN DATE

_____

SIGNATURE

REVIEWED BY:

_____ _____

SIGNATURE OF DOCTOR DATE