

CAROLINA PODIATRY GROUP, INC – PATIENT INFORMATION

FIRST NAME _____ M.I. _____ LAST NAME _____

SSN# _____ - _____ - _____ DATE OF BIRTH ____/____/____ EMAIL: _____

MAILING ADDRESS: _____

(CITY) (STATE) (ZIP CODE)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MAY WE LEAVE A MESSAGE AT THE ABOVE NUMBERS? Y or N WHO MAY WE SPEAK WITH CONCERNING YOUR MEDICAL CARE? _____

FAMILY DOCTOR (PCP): _____ DATE LAST SEEN@PCP _____

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER: _____ GENDER: MALE FEMALE

RACE: WHITE BLACK/AFRICAN AMERICAN HISPANIC/LATINO OTHER: _____

EMERGENCY CONTACT: _____ PHONE: _____

MARITAL STATUS: M D S W STUDENT STATUS: FULL-TIME PART-TIME NON-STUDENT

EMPLOYMENT STATUS: FULL-TIME PART-TIME UNEMPLOYED RETIRED

PLACE OF EMPLOYMENT: _____

JOB TITLE: _____ HOURS/DAY _____

INSURANCE INFORMATION

PRIMARY INS _____ POLICY HOLDER _____ BIRTHDATE _____

ID# _____ GROUP# _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

SECONDARY INS _____ POLICY HOLDER _____ BIRTHDATE _____

ID# _____ GROUP# _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

TERTIARY INS _____ POLICY HOLDER _____ BIRTHDATE _____

ID# _____ GROUP# _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

_____ DATE

 SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

ALL DEDUCTIBLES AND/OR COPAYS ARE DUE ON THE DAY OF SERVICE....TODAY!

INITIAL HEALTH HISTORY
(CONFIDENTIAL)

NAME: _____ DATE: _____

What is the reason for your visit today? (Circle All That Apply)

- | | | | | |
|-----------------|--------------------|--------------|-------------------|-------|
| ANKLE PAIN | DERMATITIS (Rash) | FUNGAL NAILS | INGROWN NAILS | WART |
| BUNION | DIABETIC FOOT CARE | HAMMERTOES | ROUTINE FOOT CARE | OTHER |
| CORNS/CALLOUSES | FOOT PAIN | HEEL PAIN | ULCERS | |

WHAT IS YOUR SHOE SIZE? _____ ALLERGIES: FOOD - _____ INSECTS - _____

DRUG ALLERGIES - _____

WHAT MEDICATIONS ARE YOU TAKING?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY NAME: _____ PHONE: _____

PHARMACY ADDRESS: _____

PAST MEDICAL HISTORY: CHECK CONDITIONS YOU CURRENTLY HAVE OR HAD IN THE PAST.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> COPD | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes: type ____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Pace Maker/Defib. | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis: type _____ | <input type="checkbox"/> Polio | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Cancer | | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cataracts | | | |

PAST SURGERIES: PLEASE LIST ALL SURGERIES THAT YOU HAVE HAD (NOT JUST FOOT RELATED):

FAMILY HISTORY: DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE ANY MAJOR MEDICAL PROBLEMS? IF SO, LIST WHO AND WHAT: _____

SOCIAL HISTORY: DO YOU DRINK ALCOHOL? Y or N IF YES, HOW OFTEN? _____

DO YOU SMOKE OR USE TOBACCO? Y or N IF YES, # OF PACKS/DAY? _____ HOW LONG? _____ YRS

IF YOU PREVIOUSLY SMOKED OR USED TOBACCO, HOW LONG SINCE YOU QUIT? _____

DO YOU OR HAVE YOU EVER USED ILLEGAL DRUGS? Y or N DID YOU GET A FLU SHOT THIS YEAR? Y or N

NAME: _____

DATE: _____

REVIEW OF SYSTEMS: CHECK SYMPTOMS YOU **CURRENTLY** HAVE OR HAD IN THE **RECENT** PAST.

CONSTITUTIONAL

- | | | |
|--|---------------------------------------|--|
| <input type="radio"/> ABUSE/NEGLECT | <input type="radio"/> DIZZINESS | <input type="radio"/> NIGHT SWEATS |
| <input type="radio"/> ADDICTION | <input type="radio"/> CONVULSIONS | <input type="radio"/> SLEEP PROBLEMS |
| <input type="radio"/> ANXIETY | <input type="radio"/> DEHYDRATION | <input type="radio"/> INCREASED THIRST |
| <input type="radio"/> DECREASED APPETITE | <input type="radio"/> FAINTNESS | <input type="radio"/> TIREDNESS |
| <input type="radio"/> INCREASED APPETITE | <input type="radio"/> HOT FLASHES | <input type="radio"/> VERTIGO |
| <input type="radio"/> CHILLS | <input type="radio"/> MAJOR TRAUMA | <input type="radio"/> SUDDEN WEIGHT GAIN |
| <input type="radio"/> FEVER | <input type="radio"/> MIGRAINE | <input type="radio"/> SUDDEN WEIGHT LOSS |
| <input type="radio"/> HEADACHE | <input type="radio"/> NAUSEA/VOMITING | |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="radio"/> ANKLE SWELLING | <input type="radio"/> COLD HANDS | <input type="radio"/> NUMBNESS |
| <input type="radio"/> CALF CRAMPS | <input type="radio"/> CRUSHING PAIN IN CHEST | <input type="radio"/> PAIN IN LEFT SHOULDER |
| <input type="radio"/> FEET/LEGS PALE, DISCOLORED
OR BLUISH | <input type="radio"/> ELEVATED BLOOD PRESSURE | <input type="radio"/> RACING HEARTBEAT |
| <input type="radio"/> COLD FEET | <input type="radio"/> HEART FLUTTERS | <input type="radio"/> SHORTNESS OF BREATH |
| | <input type="radio"/> JAW PAIN | <input type="radio"/> TIGHTNESS IN CHEST |

ENDOCRINE

- INCREASED THIRST
- INCREASED HUNGER
- INCREASED URINATION

ENMT

- | | |
|--|---|
| <input type="radio"/> BLEEDING GUMS | <input type="radio"/> DRY THROAT/MOUTH |
| <input type="radio"/> BLISTERS IN MOUTH | <input type="radio"/> LOST SENSE OF SMELL |
| <input type="radio"/> BLOODY NASAL DISCHARGE | <input type="radio"/> RECENT NOSEBLEED |
| <input type="radio"/> COUGHING UP BLOOD | <input type="radio"/> RINGING IN EARS |
| <input type="radio"/> DRY COUGH | <input type="radio"/> RUNNY NOSE |
| <input type="radio"/> COUGHING UP PHLEGM | <input type="radio"/> SINUS CONGESTION |
| <input type="radio"/> DIFFICULTY HEARING | <input type="radio"/> SORE THROAT |
| <input type="radio"/> DIFFICULTY SWALLOWING | <input type="radio"/> STUFFY NOSE |

EYES

- VISION LOSS
- BLURRED VISION
- CATARACTS
- CONTACTS
- DRY EYES
- GLASSES
- GLAUCOMA
- ITCHY EYES
- SENSITIVITY TO LIGHT

GI

- | | |
|--|--|
| <input type="radio"/> ABDOMINAL PAIN | <input type="radio"/> HEARTBURN/ INDIGESTION |
| <input type="radio"/> ABDOMINAL CRAMPS | <input type="radio"/> HEMORRHOIDS |
| <input type="radio"/> BLOATING | <input type="radio"/> LAXATIVE USE |
| <input type="radio"/> BLOOD IN STOOL | <input type="radio"/> NAUSEA |
| <input type="radio"/> BOWEL CHANGES | <input type="radio"/> RECTAL BLEEDING |
| <input type="radio"/> CONSTIPATION | <input type="radio"/> VOMITING |
| <input type="radio"/> DIARRHEA | |
| <input type="radio"/> GAS | |

GU

- PAINFUL URINATION
- BLOOD IN URINE
- BURNING IN URINATION
- LACK OF BLADDER CONTROL
- FREQUENT URINATION AT
NIGHT
- INCREASED URINATION

IMMUNOLOGIC

- ARTHRITIC FLARE-UP
- RECENT ASTHMA ATTACK
- COUGHING
- EYES WATERING
- GOUTY ATTACK
- HAY FEVER
- HEPATITIS B CARRIER
- SEASONAL ALLERGIES
- SENSITIVITY TO DUST
- SNEEZING

LYMPHATIC

- ANKLE SWELLING
- BLEEDING PROBLEMS
- BLOATING
- CALF PAIN
- FACIAL SWELLING
- FATIGUE
- FREQUENT NOSEBLEEDS
- RECENT NIGHT SWEATS
- RECENT TRANSFUSION
- WATER RETENTION

NAME: _____

DATE: _____

REVIEW OF SYSTEMS(continued): CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAD IN THE RECENT PAST.

SKIN

- BLISTERS
- BRUISE EASILY
- BURNING OF SKIN
- DRY, SCALY SKIN
- ECZEMA
- HAIR LOSS
- HIVES
- ITCHY SKIN
- NAIL CHANGES
- NON-HEALING WOUND
- RASH
- SUNBURN
- SCARS
- TINGLING SENSATION

MUSCLE

- ABDOMINAL PAIN
- BACK PAIN
- DECREASED RANGE OF MOTION
- HEEL PAIN
- HIP PAIN
- JOINT REDNESS
- JOINT SWELLING
- LEG CRAMPS
- MUSCLE TENDERNESS
- NECK PAIN
- WEAKNESS

NEUROLOGICAL

- FACIAL TICK
- NUMBNESS
- PARALYSIS
- RECENT SEIZURE
- TINGLING
- TREMORS
- UNCONTROLLED MOVEMENTS

PSYCHIATRIC

- ADDICTION TO ALCOHOL
- ANXIOUSNESS
- ATTEMPTED SUICIDE
- CLAUSTROPHOBIA
- UNCONTROLABLE CRYING
- DEPRESSION
- DISORIENTATION
- EMOTIONAL/MENTAL ABUSE
- FORGETFULNESS
- INDUCED VOMITING
- IRRITABILITY
- MEMORY LOSS
- NIGHTMARES
- PANIC ATTACKS
- PARANOIA
- POOR ANGER CONTROL
- RAPE/SEXUAL ABUSE VICTIM
- DIFFICULTY SLEEPING
- SUICIDAL THOUGHTS

RESPIRATORY

- DIFFICULTY BREATHING
- CHEST TIGHTNESS
- COLD-LIKE SYMPTOMS
- PERSISTENT COUGHING
- COUGHING UP BLOOD
- COUGHING UP PHLEGM
- RECENT ASTHMA ATTACK
- SLEEP APNEA
- SHORTNESS OF BREATH
- WHEEZING

By signing below, you state that the information provided above is accurate to the best of your knowledge. You also understand that this information is being gathered for the purpose of treating your foot condition as it may be caused by or affected by other underlying medical conditions. We may also use this information to assist emergency personnel in treating you if a medical emergency should arise.

Signature of Patient or Legal Guardian

Date

FOR OFFICE USE ONLY

WEIGHT: _____ HEIGHT: _____ TEMP: _____ BP: _____/_____ PULSE: _____