HARLIS FAMILY FOOT AND ANKLE

WHERE YOUR FOOT CARE IS A FAMILY MATTER

DATE:____/_____/_____

PATIENT NAME:____

DATE OF BIRTH:____/____/____ AGE:____ SEX: M F

HOME ADDRESS:______________________________________

CITY/STATE:________________________ ZIP:_____________

HOME PHONE #: (_____)_____-________

WORK PHONE #: (_____)_____-________

CELL PHONE #: (_____)_____-________

E-MAIL:_____________________________________

SOCIAL SECURITY #:__________________________________

MARITAL STATUS:___________________________

PRIMARY LANGUAGE: __________________________

RACE:____

ETHNICITY:____________________________________

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

IF YES, NAME:____________________________ RELATIONSHIP:_____________

PHONE #:(_____)_____-_______

EMERGENCY CONTACT:____________________________ RELATIONSHIP:_____________

PHONE #:(_____)_____-_______

PRIMARY CARE DOCTOR:____

Patient Name:
Date of Birth:

HARLIS FAMILY FOOT AND ANKLE

WHERE YOUR FOOT CARE IS A FAMILY MATTER

PHONE:___________________________________

PHARMACY:______________________________ ADDRESS:___________________________

PHONE #:(_____)_____-_______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION WITH? YES NO

IF YES,
NAME(S)____

____

WHO IS RESPONSIBLE FOR PAYMENT? _______________________________

RELATIONSHIP TO PATIENT? ________________ ADDRESS:_________________________

CITY/STATE:_________________ ZIP:_________ PHONE #:(_____)_____-______

WHO REFERRED YOU TO US?

____

INSURANCE INFORMATION:
PRIMARY INSURANCE COMPANY NAME:

____

ADDRESS:________________________ CITY/STATE:_________________ ZIP:_________

PHONE #:(_____)_____-______ INSURED NAME:___________________________

DATE OF BIRTH ______________ EMPLOYER ____________________________

CONTRACT # __________________ GROUP # ____________________

SECONDARY INSURANCE COMPANY NAME:

____

ADDRESS:________________________ CITY/STATE:_________________ ZIP:_________

Patient Name:
Date of Birth:

HARLIS FAMILY FOOT AND ANKLE

WHERE YOUR FOOT CARE IS A FAMILY MATTER

PHONE #:(_____)_____-______ INSURED NAME:_________________________

DATE OF BIRTH _____________ EMPLOYER __________________________

CONTRACT # _________________ GROUP # ___________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE

PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

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

REASON FOR HOSPITALIZATION	DATE

Patient Name:
Date of Birth:

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

____

____

____

____

____

____

____

____

SOCIAL HISTORY (PLEASE CIRCLE)

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE

CURRENT USE: RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT CURRENTLY SMOKING

SMOKE ____ PACKS/DAY FOR ____ YEARS

IF NO LONGER SMOKING, HOW LONG AGO DID YOU QUIT? _________

USE OF RECREATIONAL DRUGS: NEVER QUIT HOW LONG AGO? _________

TYPE _______________________

CURRENT USE : TYPE _______________ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _______________________________________

OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? YES NO

Patient Name:

Date of Birth:

CHILDREN – AGE(S)_______________

ELDERLY OR DISABLED FAMILY MEMBER OTHER
____

PET(S) – WHAT KIND? ________________________

EXERCISE: NEVER RARE OCCASIONAL WEEKLY
SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE:
____
____

FAMILY HISTORY (PLEASE CIRCLE)

DO YOU HAVE A FAMILY HISTORY OF: DIABETES: TYPE 1 OR TYPE 2

CANCER HEART DISEASE HIGH BLOOD PRESSURE STROKE

CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS

OTHER (LIST BELOW)
____
____

YOUR MEDICAL HISTORY
ALLERGIES: (PLEASE CIRCLE)
MEDICATIONS TAPE IODINE SHELLFISH ANESTHESIA LATEX
FOODS

IF ANY ABOVE CIRCLED, PLEASE LIST BELOW ALONG WITH YOUR REACTION
____
____
____
____

Patient Name:
Date of Birth:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(PLACE X NEXT TO THOSE THAT APPLY)

ACID REFLUX		FIBROMYALGIA		NEUROPATHY		ANEMIA	
GOUT		OPEN SORES		ARTHRITIS		HEART ATTACK	
PENUMONIA		ASTHMA		HEART DISEASE		HEART FAILURE	
POLIO		BACK TROUBLE		HEPATITIS		RHEUMATIC FEVER	
BLADDER INFECTIONS		HIV/AIDS		SICKLE CELL DISEASE		HIGH BLOOD PRESSURE	
ABNORMAL BLEEDING		SKIN DISORDER		BLOOD CLOTS		KIDNEY DISEASE	
SLEEP APNEA		BLOOD TRANSFUSION		LIVER DISEASE		STOMACH ULCERS	
BRONCHITIS		EMPHYSEMA		LOW BLOOD PRESSURE		STROKE	
CANCER		MIGRAINE/HEADACHES		THYROID DISEASE		DIABETES TYPE 1	
DIABETES TYPE 2		MITRAL VALVE PROLAPSE		SPINAL STENOSIS		COPD	

CURRENT PROBLEM
WHAT SPECIFIC PROBLEM(S) BRINGS YOU TO OUR OFFICE TODAY?

____

____

HOW LONG AGO DID THIS PROBLEM FIRST START? _______________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM (CIRCLE ONE):

BEGIN ALL OF A SUDDEN OR GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN (CIRCLE ONE)? 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)

Patient Name:
Date of Birth:

(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(CIRCLE ONE):

STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?

____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

____

WAS THIS PROBLEM CAUSED BY AN INJURY (CIRCLE ONE)? NO YES
(DESCRIBE)____
IF YES, WAS IT A WORK-RELATED INJURY? YES NO

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 IF OTHER THAN PATIENT

____
RELATIONSHIP TO PATIENT

Patient Name:
Date of Birth: