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Patient History Form

Patient Name:_____ Date of Birth:_____/_____/_____

Social Security Number:_____-_____-_____ Age:_____ Sex(circle): F M

Marital Status (circle): Single Married Divorced Widowed Legally Separated Partner

Race:_____ Hispanic/Latino? Yes No

Legal Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

If patient is a **MINOR**, parent's Name:_____SS#:_____-_____-_____

PATIENT'S EMPLOYER(circle) Unemployed Retired Disabled Student

Company:_____ Occupation:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Primary Care Physician (PCP):_____

Phone:_____ Date Last Seen:_____

Preferred Pharmacy:_____ Phone:_____

INSURANCE INFORMATION (Must be completed entirely)

Insurance:_____ Policy Holder (if not self):_____

Relationship to Patient:_____ Policy Holders DOB:_____

PRIVACY INFORMATION PREFENCES

Were you offered a copy of the HIPPA Privacy Practices Notice? _____Yes _____No

Do you want to be exempt from public reporting? _____Yes _____No

May we send mail to the address on file? _____Yes _____No

May we call the phone number on file? _____Yes _____No

May we leave a voicemail on answering machine? _____Yes _____No

Will you allow internet based delivery reminders like email? _____Yes _____No

With whom may we leave messages? _____Wife _____Husband _____Daughter _____Son _____Other

Do you have a Living Will? _____Yes_____No DNR? _____Yes_____No

Do you have a Power of Attorney?_____Yes_____No. If so, Name:_____

AS OF July 1, 2007, IMPERIAL POINT PODIATRY ASSOCIATES, WILL NOT BE CARRYING MALPRACTICE INSURANCE. IF THIS CAUSES ANY PROBLEMS, PLEASE NOTIFY THE STAFF. BY SIGNING BELOW, I ACKNOWLEDGE THAT I UNDERSTAND THE ABOVE INFORMATION.

_____ **Date:**_____

REASON FOR VISIT TODAY_____

How long has this bothered you(circle)**? 1 2 3 4 5 6 7 8 9 10 Days Weeks Months Years**

On a pain scale of 1-10, (1 being no pain and 10 being the worst) what is your level of pain? _____**/10**

The pain is (circle): burning constant dull sharp shooting throbbing tingling other:_____

Are you currently **PREGNANT**(circle)**?** Yes No Do you take **ORAL CONTRACEPTIVES**(circle)**?** Yes No

Are you **physically impaired** in any way?_____

Do you have a **PACEMAKER?**_____

Have you been a patient in a hospital in the past year(circle)? Yes No Reason:_____

MEDICAL HISTORY (Patient and Family) (check ALL that apply)

	SELF	**FATHER**	**MOTHER**	**BROTHER**	**SISTER**
AIDS (V02.9)	☐	☐	☐	☐	☐
Arthritis (V13.4)	☐	☐	☐	☐	☐
Cancer (199.1)	☐	☐	☐	☐	☐
Diabetes (250.00)					
Insulin	☐	☐	☐	☐	☐
Non-Insulin	☐	☐	☐	☐	☐
Gout (274.9)	☐	☐	☐	☐	☐
Heart Disease (429.9)	☐	☐	☐	☐	☐
Hepatitis A	☐	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐
High Blood Pressure (V12.59)	☐	☐	☐	☐	☐
Neuropathy (386033)	☐	☐	☐	☐	☐
OTHER:					
_____	☐	☐	☐	☐	☐

SURGICAL HISTORY:

Do you have artificial joints (circle)? Yes No Have you had foot/ankle surgery (circle)? Yes No

List **ANY** past surgeries:_____

_____

HABITS:

Do you smoke cigarettes (circle): Current : how much?_____ Former Never

Do you drink alcohol (circle)? No Yes how much per week?_____

Do you use recreational drugs (circle)? No Yes how much per week?_____

CURRENT MEDICATIONS NONE

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

Name:_____Dose:_____How often:_____

ALLERGIES(circle): None Known Allergies Penicillin Iodine Aspirin Codeine Sulfa Shellfish Latex Tape

Other:_____

WEIGHT:_____**HEIGHT:**_____

SHOE SIZE:_____**SHOE WIDTH:**_____