Pueblo Ankle & Foot Care, PLLC

Chart #_____

Name:_____ DOB:_____

Email:_____ SSN:_____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Demographics

Address:_____ City:_____ State:_____ Zip:_____

Home#:_____ Cell#:_____ Other#:_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Declined to Specify

Primary Care Doctor:_____ Date Last Seen:_____

Other Medical Provider(s):_____Date Last Seen:_____

Phone#(s):_____ Address(es):_____

HIPPA (Privacy Act)

Do you want to be exempt from public reporting?☐Yes ☐ No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐ No Can we leave voice mail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

Will you allow electronic access to the patient portal? ☐Yes ☐No

Next of kin:_____Relationship:_____POA:☐Yes ☐ No

Emergency Contact:_____ Phone number: _____ Relationship:_____

Who can we leave messages with?☐Wife ☐Husband ☐Daughter ☐Son ☐Other:_____Name(s):_____

Insurance Information

Primary Insurance:_____ Policy ID:_____ Group ID:_____

Are you the subscriber? ☐Yes ☐No Subscriber Name:_____ Employer:_____

Relationship to subscriber: ☐ Spouse ☐ Child ☐ Self ☐ Other Sex: ☐ Male ☐ Female DOB:___/___/___

Phone #:_____ Address:_____

Secondary Insurance:_____ Policy ID:_____ Group ID:_____

Are you the subscriber? ☐Yes ☐No Subscriber Name:_____ Employer:_____

Relationship to subscriber: ☐ Spouse ☐ Child ☐ Self ☐ Other Sex: ☐ Male ☐ Female DOB:___/___/___

Phone #:_____ Address:_____

How did you find out about our practice? ☐Phone book ☐Physician/Referral ☐Friend/Family Member ☐Letter ☐ Advertisement ☐Spirit of Women ☐Health Fair/Event ☐Website_____ ☐Other(specify):_____

Name of person who referred you?_____ Phone # for friend/family referral:_____

Please read and sign

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient/responsible party signature:_____ Date:_____

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Chart #_____

Name:_____ DOB:_____

History & Physical

What is the reason for your visit today?_____

Please indicate ☐ Right ☐ Left or ☐ Both and location ☐ Ankle(s) ☐ Foot(feet) ☐ Toe(s) ☐ Toenail(s) ☐ Other

Was this due to an injury ☐ Yes ☐ No Date of Injury__/__/____ Where? ☐ Auto accident ☐ Home ☐ Other ☐ Work

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective?_____

_____

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

The pain quality is ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling ☐ other:_____

☐Liver	☐Sleep Apnea	☐Thyroid	☐Heart Disease	☐Skin Disorder
☐Heart Murmur	☐Stomach Disorder	☐Circulation	☐Mental Illness	☐Difficulty Breathing
☐Blood Clot	☐High Cholesterol	☐Allergies	☐Cancer	☐Asthma
☐Neuropathy	☐Blood Disorder	☐Anxiety Disorder	☐Diabetes Type 1	☐Kidney Disease
☐Arthritis	☐Gout	☐High Blood Pressure	☐Diabetes Type 2	☐Hepatitis
☐Alcoholism	☐ Depression	☐Musculoskeletal	☐HIV	☐CVA
				☐Stroke

Other *(specify)*:_____

Are you pregnant? ☐ Yes or ☐ No Are you nursing? ☐ Yes or ☐ No

Surgical History

☐ **None** ☐ Angioplasty ☐ Appendectomy ☐ By-pass ☐ Cataracts ☐ C-Section ☐ Cholecystectomy(gallbladder)

☐ Other Surgeries (*specify*):_____

_____

Have you ever had any surgical procedures on foot/ankle? ☐ Yes/☐ No *(specify)*:_____

Do you have metal or medical devices in your body? ☐ Yes/☐ No *(specify)*:_____

Any complications with anesthesia? ☐ Yes/☐ No *(specify)*:_____

Social History

Are you a current smoker? ☐Yes/☐No/☐Never If yes, how many packs per day_____ or cigarettes a day _____?

If a current/former smoker what year did you start:_____ if former what year did you quit:_____

Do you drink alcohol? ☐ Yes, everyday ☐ Yes, occasionally/socially ☐ Yes, rarely ☐ No

Do you smoke marijuana? ☐ Yes/☐ No How often?_____

Substance abuse problem? ☐ Yes/☐ No *(specify)*:_____

What is your occupation?_____ Does it involve mostly ☐standing or ☐sitting?

Do you exercise regularly? ☐No/☐Yes, I do the following regular exercise:_____

What is your shoe size?_____ How tall are you?_____' _____" How much do you weigh?_____

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History & Physical Continued

Chart #_____

Name:_____ DOB:_____

Family History

Please list **biological** family health history including only parent(s), sibling(s) or child(children):

☐Alzheimer's	_____	☐Cataracts	_____	☐Diabetes Type I or II	_____
☐Arthritis	_____	☐Circulation Disorder	_____	☐Emphysema	_____
☐Bleeding Disorder	_____	☐Other Circulation	_____	☐Heart Disease	_____
☐Blood Clot	_____	☐Dementia	_____	☐High Blood Pressure	_____
☐Cancer	_____	☐Depression	_____	☐Neurological	_____
☐Other_____				☐Strokes	_____

Medications

Current Medications

☐Not currently taking medications
☐I take the following medications
☐I provided a list to the receptionist

Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____

Allergies

☐No known allergies
☐No known drug allergies
☐I provided a list to the receptionist

Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____

Review of Systems

Cardiovascular:☐N**ONE** ☐Cold hands/feet ☐Congestive heart failure ☐Leg pain w/rest ☐Leg pain w/walking ☐Leg swelling ☐Pacemaker ☐Palpations ☐Valve problems ☐Vericose veins ☐Vascular disease

Gastrointestinal:☐**NONE** ☐Abdominal pain ☐Blood in stool ☐Constipation ☐Decrease appetite ☐Diarrhea ☐Heart burn ☐Increase appetite ☐Trouble swallowing ☐Ulcers ☐Vomiting

Genitourinary: ☐**NONE** ☐Blood in urine ☐Decrease frequency ☐Excessive urination ☐Hesitancy ☐Incontinence ☐Increased urgency ☐Kidney disease ☐Kidney stones

Hematologic: ☐**NONE** ☐Anemia ☐Blood thinners ☐Clotting disorders ☐Lower leg ulcers ☐Sickle cell disease

Integumentary:☐**NONE** ☐Athletes foot ☐Dry, scaly skin ☐Eczema ☐Itchiness ☐Nail abnormalities ☐Keloids

Musculoskeletal:☐**NONE** ☐Arthritis ☐Back pain ☐Gout ☐Hip pain ☐Joint instability ☐Joint pain ☐Joint swelling ☐Knee pain ☐Muscle pain ☐Muscle weakness ☐Neck pain ☐Sciatica

Neurological: ☐**NONE** ☐Dizziness ☐Headaches ☐Numbness ☐Paralysis ☐Seizures ☐Tingling ☐Weakness

Respiratory ☐**NONE** ☐Chest pain ☐COPD ☐Coughing ☐Emphysema ☐Shortness of breath ☐Snoring