Chart #_____

Pueblo Ankle & Foot Care, PLLC

Name:_____ DOB:_____

Email:_____ SSN:_____

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

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):_____

Insurance Information

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

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

Employer:_____ Address:_____ Phone #:_____

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:_____ Address:_____ Phone #:_____

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

Phone #:_____ Address:_____

How did you hear about Pueblo Ankle and Foot Care? ☐Phone book ☐Letter ☐Quality Connections ☐Event ☐Spirit of Women ☐Health Fair ☐Friend/Family Member ☐Other(specify):_____

☐Our Website ☐Google ☐Online listing, please specify site (FB, Healthgrades etc):_____

☐Physician/Referral & Name of the Doctor:_____

Who may we thank for referring you to our practice?_____

Please give us phone # **&** address 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:_____

Patient/responsible party name:_____

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HIPAA (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 us to send text delivery of reminders? ☐Yes ☐No Preferred cell number:_____
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):_____

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 did the injury occur? ☐Auto accident ☐Home ☐Other ☐Work

How long has this bothered you? 1 2 3 4 5 6 7 8 9 10 ☐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:_____

History & Physical

☐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 Type1	☐Kidney Disease
☐Arthritis	☐Gout	☐High Blood Pressure	☐Diabetes Type2	☐Hepatitis
☐Alcoholism	☐ Depression	☐Musculoskeletal	☐HIV	☐CVA
Other *(specify)*:_____				☐Stroke

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

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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?_____

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	_____

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History & Physical Continued

Chart #_____

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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: ☐**NONE** ☐Cold hands/feet ☐Congestive heart failure ☐Leg pain w/rest ☐Leg pain w/walking ☐Leg swelling ☐Pacemaker ☐Palpation's ☐Valve problems ☐Varicose 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 ☐Keloid's

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

Fall Risk Assessment

Any falls in the past year? ☐Yes ☐No If yes, how many? _____ If yes, any injury? ☐Yes ☐No