

**PATIENT INFORMATION:**

(Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (MI) \_\_\_\_\_ (Maiden) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home # (\_\_\_\_) \_\_\_\_\_ Mobile # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ Gender  Male  Female Gender Identity \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed  Separated  Partnered  
 Primary Care Physician \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_ Pharmacy \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Employer \_\_\_\_\_ Job Title \_\_\_\_\_  
 Employment Status  Full-time  Part-time  Retired  Self-employed  Disabled (reason) \_\_\_\_\_

**CONTACTS:**

Who can we leave a message with or discuss your medical condition including diagnosis, treatment and payment with?  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Do we have permission to communicate information regarding medications and/or appointments by:  
 Home Answering Machine  Yes  No With Another Person  Yes  No Work Answering Machine  Yes  No  
 Send Via E-mail/Portal  Yes  No Cell Phone Voice Mail  Yes  No Mobile Text  Yes  No

Preferred method to receive patient billing statements:  Text message  e-mail  Paper statement  
 Appointment reminder preference:  Text message  e-mail  Phone call

**INSURANCE INFORMATION:**

Primary Insurance \_\_\_\_\_ Policy ID \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other  
 Subscriber Sex  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ Policy ID: \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other  
 Subscriber Sex  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE?**

Physician \_\_\_\_\_  Google  Internet Search  Insurance Website  Facebook  
 Instagram  LinkedIn  Telephone Book  Family/Friend \_\_\_\_\_  
 Other \_\_\_\_\_

**REASON FOR VISIT:**

What is the reason for your visit today? \_\_\_\_\_  
How long has it bothered you? \_\_\_\_\_ What is your level of pain? (scale of 1 to 10) \_\_\_\_ / 10  
The pain quality is:  Burning  Constant  Dull  Sharp  Shooting  Throbbing  Tingling  Other \_\_\_\_\_  
What treatments have you tried? \_\_\_\_\_  
Is this pain/problem a result of an injury?  Yes  No Describe \_\_\_\_\_  
Is this pain/problem work related?  Yes  No Describe \_\_\_\_\_  
Former Podiatrist(s) \_\_\_\_\_ Last Visit Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL HISTORY:**

Are you Diabetic?  Yes  No Last A1C: \_\_\_\_\_ Who manages your diabetes? \_\_\_\_\_  
Date last seen by Primary Care Physician or Endocrinologist for diabetes management: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check any of the conditions that currently apply **OR** that you have experienced in the past:

- Auto-immune issues (ex. Rheumatoid arthritis, etc.): specify \_\_\_\_\_
- Bleeding/Clotting Issues: specify \_\_\_\_\_
- Breathing Issues: specify \_\_\_\_\_
- Cancer: specify \_\_\_\_\_
- Diabetes: (Type I or Type II ) year diagnosed \_\_\_\_\_
- Heart Issues: specify \_\_\_\_\_
- High Blood Pressure  High Cholesterol/lipids
- Kidney issues: specify \_\_\_\_\_
- Liver issues: specify \_\_\_\_\_
- Musculoskeletal issues (ex. Arthritis, Gout, Scoliosis, Stenosis, Fractures, etc): \_\_\_\_\_
- Neurologic issues (ex. Neuropathy, Sciatica, Migraines): specify \_\_\_\_\_
- Psychologic issues: specify \_\_\_\_\_
- Stomach issues (ex. GERD, IBD, Ulcers, etc.): specify \_\_\_\_\_
- Vascular/Venous issues (ex. Peripheral vascular disease, venous insufficiency, varicose veins): specify \_\_\_\_\_

**SURGICAL HISTORY:** Have you had any of the following surgeries?

- NONE**  Appendectomy  Female surgery  Cataract Surgery  Ear tubes  Gallbladder  Hernia
- Musculoskeletal/Foot  Tonsils/Adenoids  Vascular/Heart Surgery  Wisdom Teeth  Bone/Joint
- Other: \_\_\_\_\_

Please specify details of above: \_\_\_\_\_

Have you had any surgeries on your foot/ankle?  Yes  No  
Please list foot/ankle surgeries: \_\_\_\_\_  
Do you have any artificial joints?  Yes  No Where? \_\_\_\_\_

**FAMILY HISTORY:** Is there a family history of? (Check box for relationship and circle D if family member is deceased)

	<u>Mother</u>	<u>Father</u>	<u>Brother</u>	<u>Sister</u>		<u>Mother</u>	<u>Father</u>	<u>Brother</u>	<u>Sister</u>
High Blood Pressure	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	Cancer	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D
Bleeding Disorders	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	Blood Clot	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D
Circulation Problems	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	Diabetes	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D
Heart Disease	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	Stroke	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> D

**SOCIAL HISTORY:**

Have you had two or more falls within the last 12 months?  Yes  No

Are you currently pregnant?  Yes  No If yes, how many weeks: \_\_\_\_\_ Are you currently nursing?  Yes  No

Alcohol use:  Never  No Longer Use  Current  Rare  Occasional  Moderate  Daily

Tobacco use:  Never  Quit How long ago? \_\_\_\_\_ Current Use:  Rare  Occasional  Moderate  Daily

Tobacco type:  Cigarettes  Smokeless tobacco  Pipe  Cigar  Vape

Illicit/Recreational Drug use:  Never  Past history of  Current

Exercise:  Never  Rare  Occasional  Weekly  Several times a week  Daily

Hobbies: \_\_\_\_\_

Sports: \_\_\_\_\_

**MEDICATIONS:** (Please list below or provide a separate sheet)

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES:** Please mark any allergies you may have. List any allergies not shown.

**NO KNOWN ALLERGIES**

- Adhesive Tape Reaction: \_\_\_\_\_
- Aspirin Reaction: \_\_\_\_\_
- Codeine Reaction: \_\_\_\_\_
- Iodine Reaction: \_\_\_\_\_
- NSAIDS Reaction: \_\_\_\_\_
- Sulfa Reaction: \_\_\_\_\_
- Other: \_\_\_\_\_

- Anesthetics Reaction: \_\_\_\_\_
- Betadine Reaction: \_\_\_\_\_
- Cortisone Reaction: \_\_\_\_\_
- Latex Reaction: \_\_\_\_\_
- Penicillin Reaction: \_\_\_\_\_
- Silver Reaction: \_\_\_\_\_

**ADVANCED DIRECTIVES:**

Do you have advanced directives?  Yes  No

Do you have a living will?  Yes  No

Do you have a Durable Power of Attorney?  Yes  No If so, POA Name: \_\_\_\_\_

**TREATMENT AND INSURANCE CONSENT:**

I hereby consent and give my permission to Batavia Foot Care Center, its healthcare providers, assistants and/or designated replacement to administer and perform such procedures and treatments upon me as they deem necessary. I give consent for Batavia Foot Care Center to bill my insurance and collect payment for rendered services.

\_\_\_\_\_  
(Signature of Patient, Guardian or Representative) DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Representative (if applicable) \_\_\_\_\_ Relationship: \_\_\_\_\_