HOSPITAL PLAZA
FOOT & ANKLE INSTITUTE

Date_____

Name_____Birth Date_____

Address_____Apt #_____

City_____ Zip_____

Age_____ Gender_____ Marital Status_____

Home Phone_____Work Phone_____

E-mail_____Cell Phone_____

Soc. Sec. #_____

Shoe size_____ Ht. _____ Wt._____

Emergency Contact_____

Address_____City_____Zip_____

Phone_____ Relation_____

Pharmacy name & address _____

Pharmacy Phone # _____

Responsible for Bill_____

Primary Insurance Company_____

Secondary Insurance Company_____

Is this Workman's Comp_____Date of Accident_____

What is your present foot/ankle problem?_____

Referred by_____

Address_____

REVIEW OF SYMPTOMS
(Check any that apply)

CONSTITUTIONAL

☐Chills	☐Decline in Health	☐Fatigue
☐Fever	☐Weakness	☐Weight Gain
☐Weight Loss		

HEAD

☐Dizziness	☐Fainting	☐Head Injury
☐Headaches	☐Pain	☐Sweats

Eyes

☐Blurry Vision	☐Cataracts	☐Discharge
☐Eyeglass use	☐Glaucoma	☐Infections
☐Pain with light	☐Recent Injury	☐Redness
☐Unusual Sensations	☐Vision loss	

ENT

(Nose)

☐Discharge	☐Frequent colds	☐Hay fever
☐Infections	☐Nasal obstruction	☐Nose bleeds
☐Sinus infections		

(Mouth)

☐Bleeding Gums	☐Change in Dentition	☐Hoarseness
☐Postnasal drip	☐Tongue burning	☐Voice changes

(Ears)

☐Discharge	☐Dizziness	☐Hearing Aid
☐Hearing Impairment	☐Infections	☐Pain
☐Ringing in the ears		

(Throat/Neck)

☐Frequent sore throats	☐Lumps	☐Tenderness
☐Tonsils Enlarged		

Respiratory

☐Asthma	☐Cough	☐Wheezing
☐Bronchitis	☐Coughing Blood	☐Pain
☐Pleurisy	☐Positive TB test	☐Recent chest X-ray
☐Short of breath	☐Sputum	☐Tuberculosis

Cardiovascular

- ☐Chest pain
- ☐Extremity(s) cool
- ☐Heart murmur
- ☐History of heart attack
- ☐Rheumatic fever
- ☐Short of breath (sleeping)
- ☐Ulcers on legs
- ☐Palpitations
- ☐Extremity(s) discolored
- ☐Heart test (not EKG)
- ☐Leg pain –walking
- ☐Short of breath (exertion)
- ☐Swelling of legs
- ☐Varicose Veins
- ☐Hair loss on legs
- ☐High Blood Pressure
- ☐Recent EKG
- ☐Short of breath (Lying flat)
- ☐Thrombophlebitis

Gastrointestinal

- ☐Abdominal pain
- ☐Heartburn
- ☐Rectal bleeding
- ☐Black tarry stools
- ☐Excessive hunger
- ☐Hemorrhoids
- ☐Laxative use
- ☐Swallowing problem
- ☐Constipation
- ☐Jaundice
- ☐Abdominal X-rays
- ☐Change in frequency of BM
- ☐Excessive thirst
- ☐Hepatitis
- ☐Nausea
- ☐Vomiting
- ☐Diarrhea
- ☐Liver disease
- ☐Antacid use
- ☐Change in stool caliber
- ☐Gallbladder disease
- ☐Infections
- ☐Rectal Pain
- ☐Vomiting Blood

Musculoskeletal

- ☐Arthritis
- ☐Back Problems
- ☐Muscle cramps
- ☐Restricted motion
- ☐Joint pain
- ☐Deformities
- ☐Muscle stiffness
- ☐Weakness
- ☐Gout
- ☐Joint Stiffness
- ☐Paralysis

Psychiatric

- ☐Depression
- ☐Disturbing thoughts
- ☐Memory loss
- ☐Psychiatric disorders
- ☐Behavioral change
- ☐Excessive stress
- ☐Mood changes
- ☐Disorientation
- ☐Hallucinations
- ☐Nervousness

Breasts

- ☐Discharge
- ☐Self-examination
- ☐Lumps
- ☐Tenderness
- ☐Pain

Skin

- ☐Eczema
- ☐Easy brusiability
- ☐Hives
- ☐Nail appearance change
- ☐Skin color changes
- ☐Itching
- ☐Hair dye
- ☐Lumps
- ☐Nail texture Change
- ☐Dryness
- ☐Hair texture change
- ☐Mole increased size
- ☐Rashes

Neurological

- ☐Loss of Consciousness
- ☐Dizziness
- ☐Headaches
- ☐Paralysis
- ☐Tingling
- ☐Blackouts
- ☐Fainting
- ☐Memory loss
- ☐Speech disorders
- ☐Tremors
- ☐Burning
- ☐Head Injury
- ☐Numbness
- ☐Strokes
- ☐Unsteady gait

Endocrine

- ☐Weakness
- ☐Cold Intolerance
- ☐Goiter
- ☐Neck pain
- ☐Weight gain
- ☐Excessive Urination
- ☐Heat intolerance
- ☐Sweats
- ☐Weight loss
- ☐Fatigue
- ☐Increased thirst
- ☐Thyroid trouble

Hematologic/Lymph

- ☐Anemia
- ☐Easy brusiability
- ☐Swollen glands
- ☐Bleeding easily
- ☐Lumps
- ☐Transfusion reaction
- ☐Blood clots
- ☐Radiation Exposure

Allergic/Immunologic

- ☐Coughing
- ☐Itchy eyes
- ☐Runny nose
- ☐Watery eyes
- ☐Cough with exercise
- ☐Itchy nose
- ☐Sneezing
- ☐Wheezing
- ☐Hives
- ☐Recurrent Infections
- ☐Stuffy nose
- ☐Wheezing with exercise

Genitourinary

Male

- ☐Hernias
- ☐Venereal Disease
- ☐Pain
- ☐Prostate Problems

Female

- ☐Birth control
- ☐Recent pregnancy
- ☐Hernias
- ☐Venereal disease
- ☐Menopause
- ☐Pain

Please check the box for any medications which may cause a reaction/allergy. Please indicate what type of reaction you may have.

□No Known Allergies

□Penicillin	□Aspirin	□Darvocet	□Iodine
□Anesthetic	□Latex	□Cortisone	□Sulfa
□Novacaine	□Codeine	□Adhesive tape	□Other

Other_____

Primary Care Physician_____Date last seen_____

Address_____

Are you on a medical diet? _____

What medications are you now taking?_____

_____

Family History
Please indicate health status for each of the following close relative.
(If deceased list age and cause of death)

Father_____
Mother_____
Siblings_____
Children_____

Please check Yes or No box to indicate whether any close illnesses. If yes please indicate which relatives have the problem

	YES	No	
Diabetes	□	□	_____
Cancer	□	□	_____
Heart Disease	□	□	_____
Bleeding disorder	□	□	_____
Anesthesia problems	□	□	_____

Medical History

Please check the box for appropriate medical conditions. Please elaborate as necessary for any checked medical conditions.

☐Aids (HIV)_____	☐Diabetes_____	☐Liver Problems_____
☐Anemia_____	☐Epilepsy_____	☐Mitral Valve Prolapse_____
☐Asthma_____	☐Glaucoma_____	☐Pace Maker_____
☐Bleeding Tendencies_____	☐Heart trouble_____	☐Rheumatic fever_____
☐Blood thinner_____	☐High blood pressure_____	☐Arthritis_____
☐Bursitis_____	☐Kidney trouble_____	☐Tumors_____
☐Cancer_____	☐Leg Cramps_____	☐Varicose Veins_____

☐Other_____

List past surgeries(previous 3 years) _____

_____

Social History

Occupation_____

	Yes	No	Please list details below
Presently Employed?	☐	☐	_____
Do you Smoke? How much?	☐	☐	_____
Did you previously smoke?	☐	☐	_____
Do you use recreational drugs?	☐	☐	_____
Are you/have you ever been addicted to Any drugs, medications, or alcohol?	☐	☐	_____

If yes please specify type of addiction_____

How often do you drink alcohol per week?_____

What type of alcohol do you prefer?_____

For Insurance Purposes Please Sign

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits either to Myself or to the Party Who Accepts Assignment Below.

SIGNED _____ DATE _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW:

_____
SIGNED (Insured or Authorized Person)