

Save Your Sole Foot & Ankle Specialists

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Personal Information

Name: _____ Birth date: _____ Today's date: _____

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

Home phone: _____ Cellular phone: _____

Email address: _____

Ethnicity: African American / Asian American / Caucasian / Hispanic / Native American /
Pacific Islander (Hawaiian) / Other: _____

Preferred spoken language: _____

Age: _____ SS# last 4 digits: _____ Sex: M / F Occupation: _____

Employer: _____ Work phone: _____

Preferred pharmacy: _____ Location: _____

Primary family physician: _____

How did you hear of our clinic? _____

Marriage status (circle): Single Married Widowed Divorced Other

Emergency contact (list parent if minor): Name _____

Relationship: _____ Phone number: _____

Today, my foot/ankle complaint is: 1. _____

(if time allows) 2. _____

The condition(s) has existed for (how long)? _____

Is this related to a specific injury? _____ Date of injury? _____

Have you had this problem before? _____ How long ago? _____

Previous treatment(s)? _____

Allergic to latex? Yes No **What reactions do you get if "yes"?** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Review of Systems: (check all that applies)

In general good health Recent significant weight gain Recent significant weight loss

Eyes: Does not apply Wear glasses/contact lenses Cataracts Glaucoma Macular deg.

Ears/Nose/Mouth/Throat: Does not apply Sinusitis Swollen lymph nodes
 Difficulty hearing Using hearing aids _____ Others (please describe)

Cardiovascular: Does not apply History of heart attack DVT High blood pressure
 History of stroke Heart murmurs _____ Others (please describe)

Gastrointestinal: Does not apply History of stomach ulcer IBS Heartburn/reflux
 Hiatal hernia Hepatitis (A/B/C) Cirrhosis _____ Others (please describe)

Genitourinary: Does not apply Kidney stones Benign prostate hypertrophy (in men)
 Overactive bladder Frequent UTI _____ Others (please describe)

Please turn over →

Musculoskeletal: ___ Does not apply ___ Rheumatoid arthritis ___ Psoriatic arthritis ___ Osteoporosis
 ___ Osteopenia ___ Lower back pain/arthritis/herniated disc/pinch nerve
 ___ Osteoarthritis(where? _____) ___ Sciatica _____ Others (describe)

Skin: ___ Does not apply ___ Eczema ___ History of Athlete's foot _____ Others (describe)

Neurological: ___ Does not apply ___ Migraine headache ___ Numbness of hands ___ Seizures
 ___ Numbness of feet ___ Multiple sclerosis ___ Charcot-Marie-Tooth disease

Psychiatric: ___ Does not apply ___ Depression ___ Anxiety ___ Bipolar disorder ___ ADHD
 _____ Others (describe)

Endocrine: ___ Does not apply ___ Gout ___ Type 1 Diabetes ___ Type 2 Diabetes
 ___ Thyroid problems _____ Others(describe)

Hematologic: ___ Does not apply ___ Bleeding disorder ___ Anemia _____ Others(describe)

Allergic/Immunologic: ___ Does not apply ___ Auto-immune disease ___ HIV positive

What operations or surgeries have you had? _____

___ **Yes** ___ **No** Do you smoke tobacco? If **yes**, how much? _____ Smoking how long? _____
 If **no**, did you smoke in the past? _____ When did you quit? _____

___ **Yes** ___ **No** Do you use recreational drugs? If **yes**, how much? _____ Using how long? _____
 If **no**, did you use in the past? _____ When did you quit? _____

___ **Yes** ___ **No** Do you drink alcohol? How much do you drink? _____

___ **Yes** ___ **No** Do you exercise on a regular basis? If yes, please describe. _____

Does anything significant run in your family? (i.e. heart disease, diabetes, foot deformities) Please list all conditions. _____

If there's anything else in your medical history that may be important for your physician to know in order to facilitate your treatment? Please describe: _____

RELEASE OF MEDICAL INFORMATION

I authorize Save Your Sole Foot and Ankle Specialists to release and obtain medical information as required for my treatment and processing of my insurance claim. I realize that it is my responsibility to pay for any services rendered. A monthly billing charge will be added to all accounts over sixty days. I understand if any balance is unpaid after 60 days, it will be sent to collections. I will also be responsible for the cost of collections, plus attorney and court fees, which may amount to 50% of the original owed amount.

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Save Your Sole Foot and Ankle Specialists for the services rendered to me.

I authorize Save Your Sole Foot and Ankle Specialists to release any information needed to determine these benefits or the benefits payable for related services.

I authorize release of medical information to my primary care physician or other specialty physicians related to my treatment.

Signature: _____ Date: _____