THE FOOT AND ANKLE CLINIC OF WEST MONROE LLC

WELCOME TO OUR OFFICE!!

NEW PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY)

PATIENT NAME: _____ SEX: M/F DATE OF BIRTH: ____/_____/_____ AGE:___

LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ / _____ ZIP: _____

SSN:_____-_____-_____

HOME PHONE #: (_____)_____-_____ MARITAL STATUS: _____

CELL PHONE #: (_____)_____-_____ RACE: _____

WORK PHONE #: (_____)_____-_____ ETHNICITY:_____

E-MAIL: _____ LANGUAGE PREFERRED:_____

YOUR PREFERRED METHOD OF COMMUNICATION *(PLEASE CHECK ONE)*: ☐ HOME ☐ CELL ☐ WORK ☐ E-MAIL

MAY WE CALL AND LEAVE A MESSAGE?: ☐ YES ☐ NO MAY WE SEND TEXT MESSAGES TO YOUR CELL PHONE: : ☐ YES ☐ NO

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: (_____)_____-_____ CELL PHONE #: (_____)_____-_____

2 PEOPLE WE MAY RELEASE MEDICAL RECORDS TO:

1. NAME: _____RELATIONSHIP TO PATIENT: _____ CONTACT PHONE:(_____)_____-_____

2. NAME: _____RELATIONSHIP TO PATIENT: _____ CONTACT PHONE:(_____)_____-_____

WHO IS RESPONSIBLE FOR PAYMENT? ☐ SELF ☐ OTHER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE #: (_____)_____-_____

DOES THE PATIENT HAVE A LEGAL GUARDIAN OR HEALTH-CARE POWER OF ATTORNEY? *(PLEASE CHECK ONE ONE)*: ☐ YES ☐ NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (_____)_____-_____

PRIMARY CARE DOCTOR: _____ PHONE #: (_____)_____-_____

DATE LAST SEEN: _____

PHARMACY: _____ ADDRESS: _____ PHONE #: (_____)_____-_____

ARE YOU CURRENTLY UNDER A PAIN MANAGEMENT CONTRACT OR RECEIVING NARCOTICS OF ANY KIND FROM ANOTHER PHYSICIAN? *(PLEASE CHECK ONE ONE)*: ☐ YES ☐ NO ***IF YES, WHO?***_____

ARE YOU CURRENTLY UNDER THE CARE OF A HOSPICE?: ☐ YES ☐ NO

ARE YOU HERE TODAY FOR AN INJURY THAT OCCURRED WHILE AT WORK OR IS THIS ACCIDENT RELATED?: ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM AND THE FOLLOWING PAGES ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I MAY OBTAIN MY OWN COPY OF IT BY REQUESTING IT. I HAVE READ AND UNDERSTAND YOUR "IMPROVING YOUR OFFICE VISIT" STATEMENT. I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH YOUR "PATIENT FINANCIAL POLICY".

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN **RELATIONSHIP TO PATIENT**

_____ _____

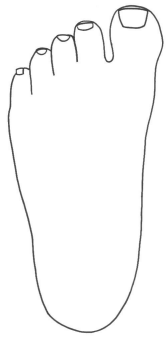
SIGNATURE **TODAY'S DATE**

CURRENT FOOT OR ANKLE PROBLEM:

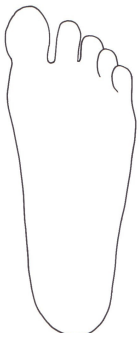
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? ***(PLEASE MARK ON THE PICTURES BELOW):***

LEFT FOOT



TOP OF FOOT

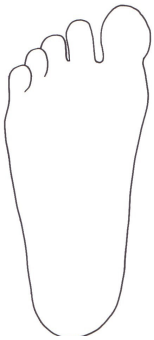


BOTTOM OF FOOT

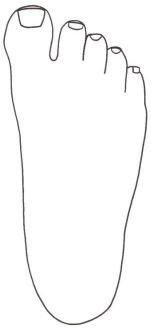
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PAIN AT WORST *(PLEASE CIRCLE ONE)*: 0 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN *(CHECK ALL THAT APPLY)*: ☐ SHARP ☐ DULL ☐ BURNING ☐ TINGLING ☐ NUMBNESS ☐ ACHING ☐ OTHER_____

_____

WAS THIS CAUSED BY AN INJURY? ☐ YES ☐ NO IF YES, PLEASE SPECIFY: _____

HAVE YOU BEEN TREATED FOR THIS CONDITION IN THE PAST? ☐ YES ☐ NO IF YES, PLEASE SPECIFY: _____

_____

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS_____

☐ FOODS _____ ☐ SULFA ☐ TAPE/ADHESIVES ☐ LATEX ☐ SHELLFISH/IODINE

☐ OTHER _____

PLEASE LIST ALL MEDICATIONS YOU TAKE OR PROVIDE US WITH A MEDICATION LIST (INCLUDING OVER THE COUNTER):

MEDICATION	DOSE	MEDICATION	DOSE

HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	OPEN SORES	Y	N
ANEMIA	Y	N	GOUT	Y	N	PAD/PVD	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	PLANTAR FASCIITIS	Y	N
ABNORMAL BLEEDING	Y	N	HEPATITIS	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HIV+/AIDS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIGH BLOOD PRESSURE	Y	N	SICKLE CELL DISEASE	Y	N
BLOOD CLOTS/DVT	Y	N	KIDNEY DISEASE	Y	N	SKIN DISORDER	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	SLEEP APNEA	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STOMACH ULCERS	Y	N
CANCER	Y	N	LUPUS	Y	N	STROKE	Y	N
CAD	Y	N	LYMPHEDEMA	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MIGRAINE HEADACHES	Y	N	TUBERCULOSIS	Y	N
EDEMA	Y	N	MITRAL VALVE PROLAPSE	Y	N	VARICOSE VEINS	Y	N
EPILEPSY/SEIZURES	Y	N	NEUROPATHY	Y	N	WARTS	Y	N
OTHER:								

SOCIAL HISTORY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE _____ PACKS/DAY FOR ____ YEARS

USE OF ALCOHOL: ☐ NEVER / NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF RECREATIONAL DRUGS: *(PLEASE NOTIFY DOCTOR IN ROOM)*

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND?_____

☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐ OTHER _____

RELATIONSHIP TO PATIENT: _____

SURGICAL HISTORY	DATE	SURGICAL HISTORY	DATE

PRIOR HOSPITALIZATIONS *(OTHER THAN SURGERIES)*: PLEASE INCLUDE REASON AND DATE

_____

_____