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:_____

HOW DID YOU HEAR ABOUT US?: _____

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

MAY WE LEAVE A MESSAGE? *(PLEASE CHECK ONE)*: ☐YES ☐NO

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

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

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

DATE LAST SEEN: _____

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

EMPLOYMENT:

EMPLOYER NAME: _____ PHONE #: (____)_____-_____

OCCUPATION-CURRENT OR MOST RECENT: _____

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 #: (____)_____-_____

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 ON HOSPICE? *(PLEASE CHECK ONE ONE)* : ☐YES ☐NO

I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN MY OWN COPY OF IT BY REQUESTING IT.
SIGNATURE: _____

I HAVE READ AND UNDERSTAND YOUR "IMPROVING YOUR OFFICE VISIT" STATEMENT:
SIGNATURE: _____

I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH YOUR "PATIENT FINANCIAL POLICY" .
SIGNATURE: _____

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.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN IF OTHER THAN PATIENT

_____ _____

SIGNATURE TODAY'S DATE

ACTIVE DIAGNOSIS/PROBLEMS YOU HAVE _____
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

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

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER / NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

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

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 _____

SURGICAL HISTORY	DATE	SURGICAL HISTORY	DATE
_____		_____	
_____		_____	
_____		_____	
_____		_____	

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

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING *(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS)*

MEDICATION	DOSE	HOW OFTEN DO YOU TAKE

(IF YOU NEED MORE SPACE TO LIST MEDICATIONS, PLEASE FEEL FREE TO USE THE BACK OF THIS PAGE.)

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_____

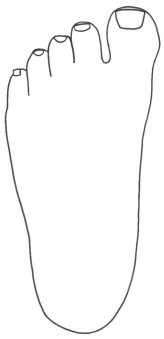
_____

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

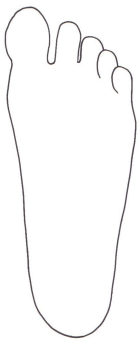
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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

LEFT FOOT



TOP OF FOOT

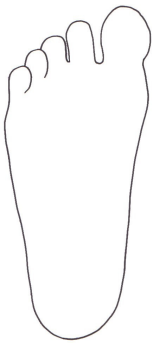


BOTTOM OF FOOT

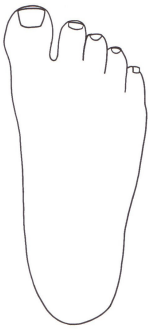
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT