PACIFIC FOOT AND ANKLE ASSOCIATES, INC.

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FOOT AND ANKLE HISTORY

Last ______________________________ First ___________________ M.I. ___ Sex ____ Age_________

Date of Birth _____________ SS#______________________________

Address: ___________________________________City________________State_______Zip____________

Home Phone: _______________ Work Phone: _____________________ Cell Phone ___________________

Marital Status: __________ Spouse/ Cohabitant____

Height___________ Weight _______________ Shoe size __________ Occupation ___________________

Emergency Contact __________________________Phone _________________ Relation _______________

REFERRING PARTY: (Please give name)

Physician: ________________________________ Phone _________________ Fax____________________

Friend ____________________________________ Family Member ________________________________

Other: ____

PRIMARY PHYSICIAN ______________________________ (☐ Check here if same as referring physician)

Phone _______________________ Fax______________________ Date of last visit ________________

Pharmacy: ____ Phone: _______________________

MAIN PROBLEM: Check one or more.

___Pain or aching ___Swelling ___Weakness ___Stiffness Deformity ___Bump ___Instability

___Infection ___Other: ____

LOCATION OF MAIN PROBLEM: ____

DURATION: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

DESCRIPTION OF ONSET: Check one or more.

☐ Congenital ☐ Crush ☐ Repetitive use ☐ Sudden onset ☐ Gradual onset

☐ Work-related ☐ Fall ☐ Twist ☐ Direct blow ☐ Sports-related

☐ No Injury ☐ Other ______________________________

SEVERITY OF THE PAIN: on a scale of 1-10 how would you rate the pain? ____________________

DISCRIPTION OF PAIN: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Other: __________

MEDICAL PROBLEMS: ☐ Diabetes ☐ Blood Pressure ☐ Cholesterol ☐ Osteo Arthritis ☐ Rheumatoid Arthritis ☐ Poor circulation ☐ Neuropathy ☐ Kidney Disease ☐ Liver Disease ☐ Dialysis

☐ Other: ______________________________

MEDICATIONS: ______________________________

ALLERGIES: ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other ______________________________

SURGERIES OR HOSPITALIZATIONS: ______________________________

FAMILY HISTORY: ☐ Diabetes ☐ Heart Disease ☐ Lung Disease ☐ Kidney Disease ☐ Arthritis ☐ Cancer

☐ Other ______________________________

Do you smoke: ___Yes ___ No I smoke ___ Packs a day for ___ Years

Do you drink: ___ Yes ___ No I have ____ drinks a ___ day ___ a week ___ Socially

Do you use illicit drugs: ___ yes ___ No I use the following drugs ____________________

BRIEFLY DRAW LOCATION OF MAIN PROBLEMS ON THE DIAGRAM ON THE NEXT PAGE.

Acknowledgement of Receipt of Notice of Privacy Practice

Our office staff is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:

Office of **Pacific Foot and Ankle Associates Inc.**

Name of Patient (Print) ______________________________

______________________________ __________

Signature of Patient or Authorized Representative Date