Welcome to Our Practice!

We're so glad that you chose us and we will do our very best to make your visit both pleasant and enjoyable.

Name _____ DOB _____

Address _____ Gender _____

City _____ State _____ Zip _____

Mobile _____

Relationship to Insured Self Spouse Child Other _____

Email _____

Preferred Pharmacy _____

Primary Care Doctor _____

Date of Last Visit to your Primary Care Doctor _____

Patient Height _____ Patient Weight _____ Shoe size _____

How did you hear about us? Google Friend Provider Directory

Other _____

Women: Currently Nursing? Yes No Currently Pregnant? Yes No

If the patient is a Minor, what is the Relationship of person Accompanying to the patient?

Father Mother Sibling Grandparent Legal Guardian Other _____

By signing below,

1. I am acknowledging that I have read or had the opportunity to read, the Notice of Privacy Practices.

2. I authorize Infinity Foot and Ankle or its staff to disclose my individually identifiable health information to insurance carrier(s) for the purpose of obtaining payment to the doctor for services rendered and allow insurance companies to process the claim. I understand that this authorization is voluntary.

_____ _____

Signature Date

Name _____ DOB _____

Allergies: None Penicillin Sulfa Iodine Latex

Other _____

Type of Allergic Reaction: Rash Itching Blisters Swelling

Other _____

Surgeries you've had: None Tonsillectomy Hysterectomy Appendectomy Bypass Angioplasty

Other surgeries _____

_____

Complications from surgery: None _____

Tobacco Use: Never Past Use Current Use Type _____

Amount per day _____ Number of Years of Use _____

Alcohol Use: Never Past Use Current Use Type _____

Recreational Drug Use: Never Past Use Current Use Type _____

Circle any symptoms you are having

General:	Fever	Chills			
Eyes:	Change in Vision	Blurred Vision	Double Vision		
Cardiovascular:	Leg Pain While Sleeping	Leg Swelling	Leg Pain While Walking		
Respiratory:	Cough	SOB			
Musculoskeletal:	Bone/Joint Pain	Sore Muscles	Weakness		
Neurologic:	Numbness	Tingling	Burning Sensation	Dizziness	Poor Balance
Endocrine:	Thirsty	Urinating Frequently			
Integument:	Rash	Itching	Wounds		

_____

_____

Name _____ DOB _____

Personal Medical History

- ☐ ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Arrhythmia
- ☐ Bipolar
- ☐ Bladder Problems
- ☐ Bleeding Problems
- ☐ Cancer _____
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ COPD/Emphysema

Other _____

_____

- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ DVT
- ☐ GERD(Reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache
- ☐ Heart Attack
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ HIV

_____

- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis

_____

What brings you into our office today? _____

Is the problem from an injury? No Yes _____

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10

Location of problem/pain?_____

Describe type of pain: Burning Throbbing Aching Stabbing Tingling

How long have you had this problem? _____

How did the problem start? Slowly over time Rapidly _____

How has the problem been over time? Worsened Stayed the same Improved

Have you seen anyone else for this problem? No Yes _____

Have you had any treatment for the problem? No Yes _____

Have you had this problem before? No Yes _____

What seems to make the problem worse? Nothing _____

What seems to make the problem better? Nothing _____

Name _____ DOB _____

Medication List

Medication Name	Medication Name

☐ Check the box if you are NOT currently taking any medications or supplements.

Office use Only

_____
_____
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