

PLEASE, PLEASE, PLEASE

**Complete ALL paper
work before returning
it to the front window.
If there is a section
that does not apply to
you, PLEASE place an X
over it and initial it!!!!**

Thank you



WASHINGTON HEALTH SYSTEM

Foot and Ankle Specialists

New Patient Information Form

Patient Name: _____

How do you want to be addressed by our office: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

Email: _____

Primary Care Physician: _____ **Last seen:** _____

How did you hear about us: _____

Date of Birth: _____ Age: _____ Sex: M or F

Race: _____ SS#: _____ Employer: _____

Occupation: _____ Work Phone #: _____

Emergency Contact: _____ **Phone #:** _____

Relationship: _____

Pharmacy: _____ Pharmacy Phone #: _____

INSURANCE INFORMATION

Subscriber Name: _____ Sex: M F DOB: _____

Subscriber ID#: _____ Subscriber Group #: _____

SS#: _____ Occupation: _____ Work Phone: _____

Relationship to Patient: _____ Subscribers Employer: _____

Subscribers Occupation: _____ Subscribers Home Phone: _____

PERSON RESPONSIBLE FOR BILL IF PATIENT UNDER 18

Name: _____ DOB: _____ SS#: _____

Address: (If different then patient): _____

Home Phone: _____ Work Phone: _____

History of Present Illness

Name: _____ DOB: _____

Patient Health History – Please circle or complete the following questions:

Medical reason for visit today: _____

Cause of problem: None, Slip/Fall, Sports/Exercise Injury, Diabetes, Unknown

Location: Right, Left, Bilateral, Great Toe, 2nd toe, 3rd toe, 4th toe, 5th toe, Foot, Forefoot,

Mid-foot, Heel, Ankle, Leg: _____

Description of pain: No pain, sharp, dull, aching, burning, radiating, shooting, itching, stabbing,

Throbbing, numbness, tingling: _____

Duration of Pain: No pain, Lasts for minutes, Lasts for hours, Continual, When weight -bearing, When

Non weight-bearing _____

Timing of Pain: No pain, started sudden, started gradual, started several days ago, started several weeks ago, started several months ago, started years ago, unknown _____

Context of when pain occurs: No pain, just out bed, as the day progresses, at the end of the day,

Only at night, improves over time _____

The following activities make the problem worse: Standing/Walking, Resting, Barefooted, Slippers,

Dress Shoes, High Heels, Flat Shoes, Closed Shoes, Daily Activities, Exercise _____

The following activities improve the problem: Standing/Walking, Resting, Barefooted, Slippers,

Dress Shoes, High Heels, Flat Shoes, Closed Shoes, Daily Activities, Exercise _____

• Injury work Related: ___ Yes ___ No If Yes Date of Injury: _____

▪ Injury auto Related: ___ Yes ___ No If Yes Date of Accident: _____

Patient has Diabetes ___ Yes ___ No if yes **Last Blood Sugar** Date: _____ Result: _____

HBA1C Date: _____ Result: _____

Pain Scale 0-10 (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10 Please circle which applies to you.

Current List of Medications

List all medication you are currently taking. Please include non-prescription medications, such as Aspirin, Tylenol, Vitamins and Herbal Supplements.

Name	Dosage/Strength	Reason

Past medical History

Check all that apply

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lumbar Stenosis
<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> Diabetes (Insulin Depend)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> GERD (Heartburn)	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> PVD (Vascular Disease)
<input type="checkbox"/> BPH (Enlarged Prostate)	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bronchitis-Chronic	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> RLS (Restless Leg Syndrome)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hyperlipidemia (High Cholesterol)	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD (Lung Disease)	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Other (Please specify)
<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/> Irritable Bowel Disease	
<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Low Back Pain	

Allergies

List all known allergies + Reason

Allergy	Reaction

Surgery History

Check all that apply and year (if known)

<input type="checkbox"/> Amputation	Year:	<input type="checkbox"/> Hip Replacement	Year:
<input type="checkbox"/> Appendectomy	Year:	<input type="checkbox"/> Hysterectomy	Year:
<input type="checkbox"/> Arthroscopy	Year:	<input type="checkbox"/> Knee Replacement	Year:
<input type="checkbox"/> Breast Lumpectomy	Year:	<input type="checkbox"/> Lap Band	Year:
<input type="checkbox"/> Bypass in Leg	Year:	<input type="checkbox"/> Ovary Removal	Year:
<input type="checkbox"/> Cardiac Bypass	Year:	<input type="checkbox"/> Pacemaker	Year:
<input type="checkbox"/> Cardiac Cath	Year:	<input type="checkbox"/> Prostate Surgery	Year:
<input type="checkbox"/> Cataracts	Year:	<input type="checkbox"/> Stent-Heart	Year:
<input type="checkbox"/> Colon Resection	Year:	<input type="checkbox"/> Stent-Kidney	Year:
<input type="checkbox"/> Colonoscopy	Year:	<input type="checkbox"/> Stent-Leg	Year:
<input type="checkbox"/> Cystoscopy	Year:	<input type="checkbox"/> Tonsils	Year:
<input type="checkbox"/> Endoscopy	Year:	<input type="checkbox"/> Tubes in Ears	Year:
<input type="checkbox"/> Gall Bladder Removal	Year:	<input type="checkbox"/> Vasectomy	Year:
<input type="checkbox"/> Gastric Bypass	Year:	<input type="checkbox"/> Other (Please specify)	Year:
<input type="checkbox"/> Hernia Repair	Year:	<input type="checkbox"/>	

Hospitalizations (WITHIN THE LAST 12 MONTHS)

Date	Reason

Family Medical History

Has any family member/relative had the following?

Illness/Type	Family Member/Relative
<input type="checkbox"/> Cancer: Breast	
<input type="checkbox"/> Cancer: Colorectal	
<input type="checkbox"/> Cancer: Ovarian	
<input type="checkbox"/> Cancer: Prostate	
<input type="checkbox"/> Cancer: Other	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Drug Abuse	
<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other	
<input type="checkbox"/> Other	

Social History

Tobacco Use: _____ Smoker _____ Smokeless _____ Non-Smoker

Have you ever used tobacco products? _____ No _____ Yes

What kind: _____ How much: _____ How many years: _____

Former Smoker-How long ago did you quit? _____

Other tobacco use (Chew, Snuff, Pipe)? _____

Alcohol and Drug Use: _____ None

Did you have a drink containing alcohol in the past year? _____ Yes _____ No

How often did you have an alcoholic drink? *Never Monthly or less 2-4/mo 2-3/wk 4 or more/wk*

What kind: _____ How much: _____ How many years: _____

Do you use drugs for reason that are not medical? () No () Yes If yes, please list _____

Review of Systems

Please circle if you are experiencing any of the symptoms below OR circle NONE

General/Constitutional:

Chills	Fever	Weight Loss	Weight Gain	None
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Ophthalmologic:

Blurred Vision	Diminished Vision	Double Vision	None
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ENT:

Decreased Hearing	Difficulty Swallowing	Nosebleeds	None
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Cardiovascular:

Chest Pain	Edema	Fluid Accumulation in Legs	Palpitations	Shortness of Breath	None
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Respiratory:

Shortness of Breath	Cough	Wheezing	None
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Gastrointestinal:

Abdominal Pain	Blood in Stool	Change in Bowel Habits	Diarrhea	Nausea	Vomiting	None
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Genitourinary:

Frequent Urination	Painful Urination	Incontinence	None
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Musculoskeletal:

Calf Pain	Back Pain	Gout	Inflammatory Arthritis	Joint Stiffness	Painful Joints	Weakness
Swollen Joints						None

Skin:

Itching Rash Skin Changes Skin Lesion(S) Sore/Ulcers None

Neurologic:

Difficulty Walking Dizziness Gait Abnormality Headaches Memory Loss
Seizures Tingling/Numbness Weakness None

Endocrine:

Hair Loss Unusual Hair Growth Cold Intolerance Excessive Thirst Frequent Urination Heat Intolerance

Hematology:

Lymph Node Swelling Fatigue Abnormal Bruising Easy Bruising None

Allergy/Immunology:

Congestion Hay Fever Hives Persistent Infections Rash None

Podiatric:

Achilles Pain Achilles Swelling Ankle Pain Ankle Swelling Pain Ball of Foot None
Big Toe Pain Big Toe Swelling Difficulty Walking Fever Foot Numbness
Joint Dislocation Redness over Achilles Sole Pain Wound oozing