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 INFORMTION

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

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

Allergies

List all known allergies + Reason

Allergy	Reaction

Surgery History

Check all that apply and year (if known)

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

Hospitalizations (WITHIN THE LAST 12 MONTHS)

Date	Reason

Family Medical History

Has any family member/relative had the following?

Illness/Type	Family Member/Relative
□ **Cancer: Breast**	
□ **Cancer: Colorectal**	
□ **Cancer: Ovarian**	
□ **Cancer: Prostate**	
□ **Cancer: Other**	
□ **High Blood Pressure**	
□ **Heart Disease**	
□ **Diabetes**	
□ **Stroke**	
□ **Depression**	
□ **Anxiety**	
□ **Glaucoma**	
□ **Alcohol Abuse**	
□ **Drug Abuse**	
□ **Thyroid Disease**	
□ **Rheumatoid Arthritis**	
□ **Other**	
□ **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

Ophthalmologic:

Blurred Vision Diminished Vision Double Vision None

ENT:

Decreased Hearing Difficulty Swallowing Nosebleeds None

Cardiovascular:

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

Respiratory:

Shortness of Breath Cough Wheezing None

Gastrointestinal:

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

Genitourinary:

Frequent Urination Painful Urination Incontinence None

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