Siouxland Podiatry Associates, PC

PATIENT INFORMATION				
First Name:	Middle Name:		Last Name:	
Social Security #:	Date of Birth / /		Age:	Sex: M F
Home Address:				
City:	State:	Zip Code:	Email:	
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )	
(Please provide mailing address if different from above):				
Preferred Method of Verbal Communication (Please circle one): Home Phone Work Phone Cell Phone			May we leave a message? Yes No	
Race: (White, Asian, etc.)	Language: (English, Spanish, etc.)	Marital Status: S M D W	Spouses Name:	
Occupation:		Employer:		
Employer Address:				
Primary Physician:			Date Last Seen:	
Referred by:				
Height:	Weight:		Shoe Size:	

IN CASE OF EMERGENCY CONTACT	
Last Name:	First Name:
Relationship:	Phone: ( )

PREFFERED PHARMACY			
Name of Pharmacy:		Phone: ( )	
Address(or cross streets):	City:	State:	Zip Code:

INSURANCE INFORMATION		
Name of Insured:	DOB: / /	Relationship:
Primary Insurance:	Phone: ( )	
Subscriber #:	Group #:	
Secondary Insurance:	Phone: ( )	
Subscriber #:	Group #:	
Responsible party (if not listed above):	Address:	
Relationship:	Phone: ( )	

Name:_____ Chart #:_____

MEDICAL HISTORY

PAST AND CURRENT MEDICAL CONDITIONS: (Example: Diabetes, High blood pressure, Cancer, etc.)

ALLERGIES: Do you have any drug or environmental allergies?	1.	3.	5.
	2.	4.	6.

MEDICATIONS: What medications are you currently taking? (Prescription medications and over the counter medications)

1.	5.	9.	13.
2.	6.	10.	14.
3.	7.	11.	15.
4.	8.	12.	16.

REVIEW OF SYSTEMS

Please indicate whether you have had any of the following medical problems

	Yes	No		Yes	No		Yes	No		Yes	No
General			**Gastroinstestinal**			**Respiratory**			**Neurological**		
Nausea/Vomiting			Stomach problems			Asthma			Stroke		
Tiredness			Hepatitis/Liver problems			Breathing problems			Dementia		
Dizziness			Colitis			Tuberculosis			Alzheimer's Disease		
Cardiovascular			Heartburn			Chronic cough			Epilepsy		
Heart Disease			Ulcers			**Musculoskeletal**			Multiple Sclerosis		
Stroke			**Genitourniary**			Rheumatoid arthritis			Paralysis		
High Blood Pressure			Incontinence			Other arthritis			Seizures		
Edema (swelling)			Prostate problems			Gout			Neuropathy (numbness)		
Cold Feet			Cancer			Joint replacement			**Integument**		
Varicose Veins			**Eyes**			Osteoporosis			Eczema		
Endocrine			Macular Degeneration			Back pain			Psoriasis		
Diabetes			Glaucoma			Morning stiffness			Ulcerations		
Thyroid Disease			Cataracts			Weakness			Athlete's Foot		
Kidney Disease			Loss of vision			Leg cramps			Excessive scarring		

FAMILY HISTORY

Please mark if any of your family have or had any of the following and indicate if it was your mother, father, brother, or sister with a M,F,B,S

	Yes	No		Yes	No
Bleeding disorder			Gout		
Cancer			Arthritis		
Heart trouble			Bunion		
High cholesterol			Bunionette		
High blood pressure			Flat feet		
Diabetes			High arched feet		
Stroke			Pigeon-toed feet		
Other (please specify)			Skin conditions		

SOCIAL HISTORY

	Yes	No	What kind, how much, how often?
Do you smoke or use tobacco products?			If quit, how long ago;
Alcohol Use?			If yes, how often;
Recreational drugs?			Specific type;
Do you exercise?			If yes, how often;
Currently employed?			Occupation;

PAST SURGICAL HISTORY

Procedure	Date	Procedure	Date
1.		4.	
2.		5.	
3.		6.	

CMS QUALITY REPORTING

	Yes	No		Yes	No
Have you had an Influenza vaccination this year?			Have you fallen in the last 12 months (65 years and older)?		
Have you had a Pneumococcal vaccination?			If yes, were you injured?		

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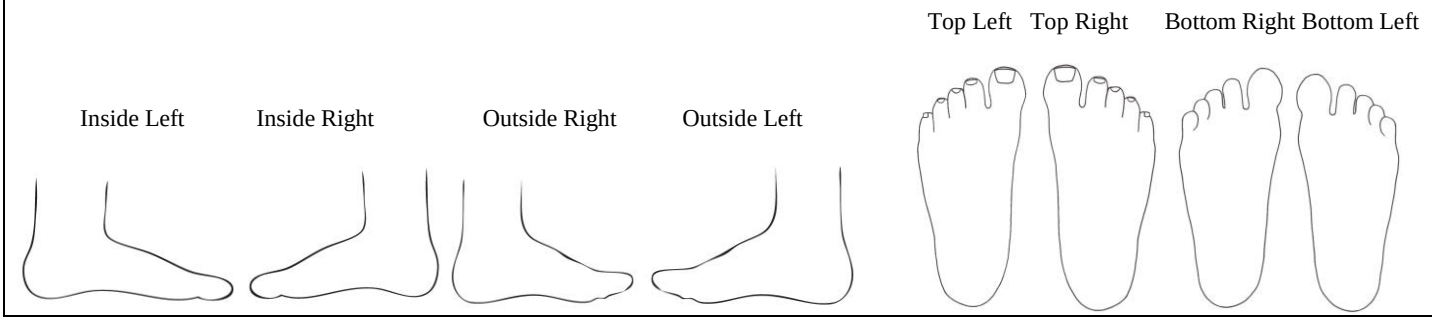
Name: _____ **Chart #:** _____

PODIATRIC HISTORY

Chief Complaint (Please provide a brief description of the nature of your illness or injury):

LOCATION

Please use the diagram to highlight the areas of your complaint. You should mark areas of injury, pain, or numbness



DURATION

How long has it been since you first noticed this condition?	
Have you ever had a similar condition in the past and is so when?	

QUALITY

How would you describe your pain (please circle)?	Sharp Shooting Burning Aching Stabbing Fullness
How would you rate your pain (please circle)?	(mild) 1 2 3 4 5 6 7 8 9 10 (severe)
Is there a time of the day that your pain seems to be at its greatest?	Morning Afternoon Night Sleeping Other:
Is there anything your do that makes this worse?	
Is there anything you do that makes this feel better (rest, ice)	

ONSET

Was this caused by an accident?	Yes No
If this was the result of an accident, please provide location and brief description.	
Was it reported to authorities or human resources (if a work injury)?	Yes No

TREATMENT

What have you tried to treat this condition?
Have you seen another physician for this condition (if yes who and when)?
Have you had any prior test for this condition?
Have you ever had prior foot surgery for this or any other condition?
Is there any other information you could share that might help in the treatment of this condition?
Physician notes: