

PATIENT INFORMATION

Patient name _____ Today's date _____
Social security # _____ - _____ - _____ Date of birth _____ Age _____
Home address _____ City _____ State _____ Zip _____
School address _____ City _____ State _____ Zip _____
Home phone (_____) _____ - _____ Work phone (_____) _____ - _____ Male _____ Female _____
Cell phone/pager (_____) _____ - _____ Email address _____
Employer _____ Occupation _____
Employer's address _____ City _____ State _____ Zip _____
Primary care physician (First and Last name) _____
Whom may we thank for referring you to our office _____
Pharmacy _____ Address _____ Phone (_____) _____ - _____

INSURANCE INFORMATION

Primary insurance _____ Policy # _____
Name of policy holder _____ Relationship to patient _____
Policy holder's date of birth _____ Holder's address _____
Policy holder's employer _____
Secondary insurance _____ Policy # _____
Name of policy holder _____ Relationship to patient _____
Policy holder's date of birth _____ Holder's address _____
Policy holder's employer _____
Is this a Worker's Compensation injury? Yes _____ No _____ Date of the injury: _____
Did the injury occur at work? Yes _____ No _____ Place of injury _____
Contact person _____ Claim # _____
Name and address to be billed _____

Describe your foot problem _____

Was this problem previously treated? YES / NO If yes, by whom? _____

I authorize the release of any medical or other information to any healthcare professional, or if necessary to process my medical billing claims. I also authorize payment of medical benefits to the above named physicians for services rendered to me by them.

Signature of Patient

Date

Signature of Guardian

Date

FOOT & ANKLE Institute
OF NEW ENGLAND

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Health History: Do you have, or have you ever had any of the following health problems?

	YES	NO		YES	NO
Bleeding tendency.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/gout.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble/ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems/murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Previous heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/tumor.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>

List any other current medical conditions you may have _____

Please list all current medications/vitamins and supplements that you are taking and their frequency. _____

Please list all medication allergies and your reaction. (example-penicillin/hives and itching) _____

Please list all hospitalizations and surgeries. _____

Please list any family history of chronic diseases/problems. (example-diabetes/father, ankle arthritis/uncle) _____

Social History:

Do you smoke? Yes No If yes, how many packs of cigarettes per day? _____ # of years? _____
 Do you drink alcoholic beverages? No Rarely Social Daily Heavy
 Do you exercise regularly? Yes No If yes, what activities do you enjoy? _____
 Single _____ Married _____ Widowed _____ Number of children _____ Height _____ Weight _____ Shoe Size _____

Review of Systems: Do you have or have you had . . .

	YES	NO		YES	NO
Weight change in the last year	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Serious problems with eyes/ears.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands/unusual lumps.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Racing heart/skipping beats.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation/diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/tightness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst.....	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol problems	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Frequent cough/wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>	Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contacts.....	<input type="checkbox"/>	<input type="checkbox"/>	Fractured/broken bones.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV (AIDS) concerns	<input type="checkbox"/>	<input type="checkbox"/>

Please give this completed form to the receptionist. The doctor will be with you shortly. Thank You!
www.FootAnkle.info