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Certified in Foot Surgery

(PLEASE PRINT)

DATE: ___/____/____ PATIENT NAME: _____ _____ ___
LAST FIRST MI

SS# _____ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #:____- ____-_____WORK PHONE #:_____-_____-_____ CELL PHONE #:____- ____-_____

E-MAIL: _____

PREFERRED METHOD OF CONTACT: _____ MAY WE LEAVE A MESSAGE? YES NO

RACE: _____ ETHNICITY: HISPANIC/LATINO **OR** NON-HISPANIC/LATINO

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: ____- ____-_____

PRIMARY CARE DOCTOR: _____
PHARMACY: _____ LOCATION: _____

WHO IS RESPONSIBLE FOR PAYMENT? _____DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: ____- ____-_____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____RELATIONSHIP_____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP_____

Authorization for Release of Information

I authorize Gateley Podiatry, P.A. to use and disclose my protected health information to the following:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

This authorization for release of information covers the period of healthcare from:

☐ All past, present and future periods **or** from _____to_____ (date range)

☐ I authorize the release of my complete medical record **or**
☐ I restrict the release of the information listed_____

I understand that this medical information may be used by the person I authorize for medical treatment or consultation; billing or claims payment; or other purposes that I may direct. I have the right to revoke this authorization in writing at any time.

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING (**INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS**):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____

WHEN WAS YOUR LAST INFLUENZA VACCINATION_____ PNEUMOCOCCAL VACCINATION_____

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

PLEASE LIST **ALL** PRIOR **SURGERIES**:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ SOCIALLY ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPES OF EXERCISE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____RELATIONSHIP: _____ PHONE #: (____) ____-_____

DO YOU HAVE A LIVING WILL? YES NO
WHO IS NAMED AS YOUR POWER OF ATTORNEY IN YOUR LIVING WILL? _____

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

YOUR MEDICAL HISTORY HEIGHT:_____ WEIGHT:_____ SHOE SIZE:_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? ☐ NO SIGNIFICANT PAST MEDICAL HISTORY

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	LUNG DISEASE	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	POLIO	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	RHEUMATIC FEVER	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIV+/AIDS	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	HIGH BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	KIDNEY DISEASE	Y	N	STOMACH ULCERS	Y	N
GOUT	Y	N	LIVER DISEASE	Y	N	STROKE	Y	N
CANCER	Y	N	LOW BLOOD PRESSURE	Y	N	THYROID DISEASE	Y	N

OTHER PROBLEMS:_____
JOINT IMPLANTS:_____

DO YOU HAVE DIABETES? YES NO TYPE 1 TYPE 2
MOST RECENT BLOOD GLUCOSE: _____MG/DL A1C:_____%
DR. MANAGING YOUR DIABETES: _____ MOST RECENT APPOINTMENT_____

WOMEN: ARE YOU PREGNANT OR POSSIBLY PREGNANT? YES NO

REVIEW OF SYSTEMS : CIRCLE ALL THAT APPLY AT THE **CURRENT TIME:**

CONSTITUTIONAL :	FEVER	CHILLS	HEADACHE		
EYES :	BLURRED VISION	SENSITIVITY TO LIGHT	WATERY EYES		
EARS/NOSE/THROAT :	DRAINAGE	CONGESTION	DIFFICULTY SWALLOWING	RINGING IN EARS	
INTEGUMENTARY :	SKIN RASH	BOILS	PERSISTENT ITCH	CALLOUS	
MUSCULOSKELETAL :	JOINT PAIN	POINT TENDERNESS	BACK PAIN	HEEL PAIN	MUSCLE PAIN
NEUROLOGICAL:	TREMORS	DIZZY SPELLS	TINGLING	NUMBNESS	
GENITOURINARY:	URINE RETENTION	PAINFUL URINATION	URINARY FREQUENCY		
ENDOCRINE:	EXCESSIVE THIRST	TOO HOT/COLD	TIRED/SLUGGISH		
RESPIRATORY:	WHEEZING	FREQUENT COUGH	SHORTNESS OF BREATH		
GASTROINTESTINAL:	ABDOMINAL PAIN	NAUSEA/VOMITING	INDIGESTION/ HEARTBURN		
CARDIOVASCULAR:	CHEST PAIN	PALPITATIONS	IRREGULAR HEARTBEAT		
HEMATOLOGIC:	SWOLLEN GLANDS	BLOOD CLOTTING PROBLEM			

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

FAMILY HISTORY DOES ANYONE IN YOUR FAMILY HAVE OR HAD ANY OF THE FOLLOWING?
PLEASE SPECIFY RELATIONSHIP (**MOTHER, FATHER, SISTER, BROTHER**)? ☐ NO SIGNIFICANT FAMILY HISTORY

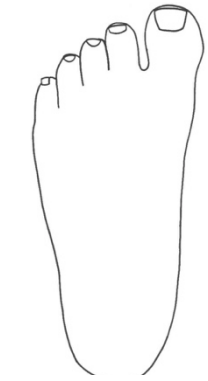
ACID REFLUX		FIBROMYALGIA		NEUROPATHY	
ANEMIA		LUNG DISEASE		OPEN SORES	
ARTHRITIS		HEART ATTACK		POLIO	
ASTHMA		HEART DISEASE/FAILURE		RHEUMATIC FEVER	
BACK TROUBLE		HEPATITIS		SICKLE CELL DISEASE	
ABNORMAL BLEEDING		HIV+/AIDS		SKIN DISORDER	
BLOOD CLOTS		HIGH BLOOD PRESSURE		SLEEP APNEA	
DIABETES		KIDNEY DISEASE		STOMACH ULCERS	
GOUT		LIVER DISEASE		STROKE	
CANCER		LOW BLOOD PRESSURE		THYROID DISEASE	

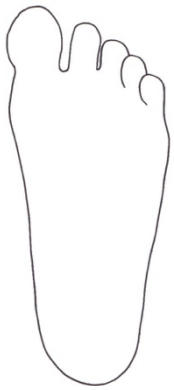
OTHER PROBLEMS:_____

CURRENT PROBLEM
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

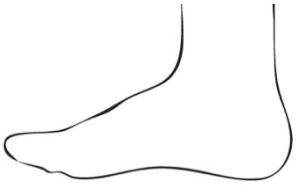
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

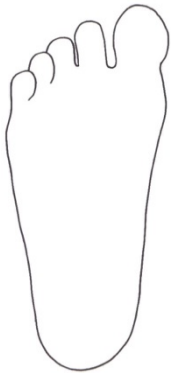

TOP OF FOOT

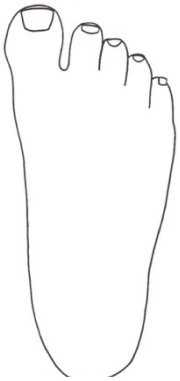

BOTTOM OF FOOT


INSIDE OF FOOT


OUTSIDE OF FOOT

RIGHT FOOT


BOTTOM OF FOOT


TOP OF FOOT


OUTSIDE OF FOOT


INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

DATE OF INJURY:_____ LOCATION OF INJURY:_____

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO
THERE MAY BE AN EXTRA FEE TO FILL OUT WORKERS COMPENSATION PAPERWORK.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE