

(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: _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ *****SELF IF AGE 18 OR OLDER**

RELATIONSHIP TO PATIENT? _____ DATE OF BIRTH: _____

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

HOW DID YOU HEAR ABOUT US? _____

PRIMARY INSURANCE COMPANY NAME: _____

POLICYHOLDER'S NAME: _____ DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICYHOLDER'S NAME: _____ DOB: _____ 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: _____

DOB: ____/____/____

PHARMACY: _____ LOCATION: _____

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

NAME	DOSE	HOW OFTEN DO YOU TAKE?
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

ALLERGIES: MEDICATIONS: _____
 LATEX TAPE SHELLFISH IODINE OTHER: _____
 NO KNOWN DRUG ALLERGIES

SURGERIES: PLEASE LIST ALL PRIOR SURGERIES:		<input type="checkbox"/> NO PRIOR SURGERIES	
TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1) _____	_____	6) _____	_____
2) _____	_____	7) _____	_____
3) _____	_____	8) _____	_____
4) _____	_____	9) _____	_____
5) _____	_____	10) _____	_____

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: _____ FULL-TIME PART-TIME RETIRED

OCCUPATION: _____

STUDENT: NO YES FULL-TIME PART-TIME

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 POWER OF ATTORNEY: _____

PATIENT NAME: _____

DOB: ____/____/____

YOUR MEDICAL HISTORY: **SHOE SIZE:** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

NO SIGNIFICANT PAST MEDICAL HISTORY

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

OTHER MEDICAL PROBLEMS: _____

DO YOU HAVE DIABETES? YES (TYPE 1 / TYPE 2) NO

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 **PRESENT 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: _____

DOB: ____/____/____

FAMILY HISTORY: DOES ANYONE IN YOUR FAMILY **HAVE OR HAD** ANY OF THE FOLLOWING?

**** PLEASE SPECIFY RELATIONSHIP (MOTHER, FATHER, SISTER, BROTHER, ETC.)**

NO SIGNIFICANT FAMILY HISTORY

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

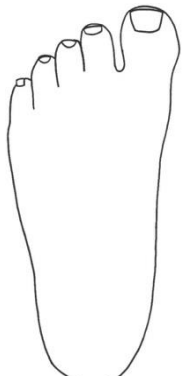
OTHER PROBLEMS: _____

CURRENT PROBLEM:

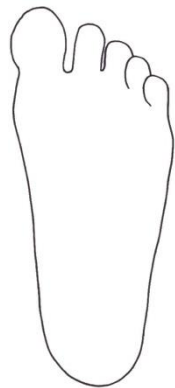
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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

LEFT FOOT



TOP OF FOOT



BOTTOM OF FOOT

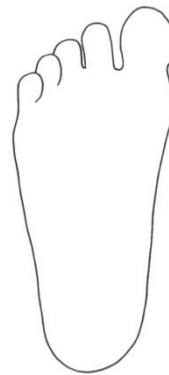


INSIDE OF FOOT

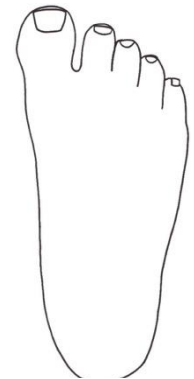


OUTSIDE OF FOOT

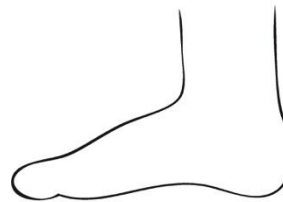
RIGHT FOOT



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: _____

DOB: ____/____/____

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

PATIENT SIGNATURE

DATE