Southwest Foot and Ankle Clinic

Patient Information Sheet

Last Name: _____ First Name/MI: _____

Nickname: _____ Sex: M F Date of Birth: _____

Mailing Address: _____ City/State: _____ Zip: _____

Preference on how you would like to be contacted: (Circle One): Home Cell Work

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

E-Mail: _____ Social Security #: _____

Marital Status: (Circle One): Single Married Divorced Widowed

Primary Language: _____

Race/Ethnicity: (Circle One): American Indian Asian Black or African American Native Hawaiian or other Pacific Islander White Hispanic or Latino Declined to Answer

Employment Status: (Circle one): Employed Student Retired

Occupation: _____ Employer: _____ Phone: ( ) _____

Spouses Name: _____ SS# _____ Spouses Employer _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy Holder (If other than patient):

Last Name: _____ First Name/ MI: _____ SS# _____

Employer: _____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy Holder (If other than patient):

Last Name: _____ First Name/MI: _____ SS# _____

Employer: _____ Date of Birth: _____

Responsible Party (If other than patient): Husband Wife Parent Other

Last Name: _____ First Name/MI: _____ SS# _____

Street: _____ City/State: _____

Phone: ( ) _____ Cell: ( ) _____

Employer: _____ Date of Birth: _____

Primary Care Physician: _____ *Who referred you to us ?* _____

Pharmacy: _____ Street _____

I authorize the release of medical information necessary to process any insurance claim. I authorize the payment of benefits to either myself or the doctor as agreed upon at the time of services rendered. I give consent for treatment to Dr. Bryan Cain or Dr. John Cauthon.

Signature: _____ Date: _____

Southwest Foot and Ankle Clinic

Patient information Sheet

Name:_____Date:_____

Primary Care Doctor:_____

Reason for your visit today:_____

Scale from *0-10* 0 is NO PAIN 10 is UNBEARABLE

Pain level today:_____Worst it has been_____Best it has been_____

LEFT foot/ankle/toes/heel_____RIGHT foot/ankle/toes/heel_____

How often does it bother you:

Constant_____ Intermittent_____ Occasional_____ Seldom_____

What is the quality of the pain:

Aching_____ Burning_____ Dull ache_____ Itching_____ Numbness_____

Sharp_____ Shooting_____ Sore_____ Stabbing_____ Throbbing_____

Tingling_____

When is the pain most bothersome:

Moderate Activity_____ Rising out of bed_____ Running_____ Standing_____

Wearing shoes_____ While walking_____

How severe is the pain:

Extreme_____ Improving_____ Moderate_____ Severe_____ Unchanging_____

Worsening_____

How long has it been bothering you:_____

Signs & Symptoms: Redness_____ Bruising_____ Swollen_____

What have you done to relieve the pain:_____

Past treatments:_____

When:_____ By whom:_____

Medical History:
Circle one

Arthritis	Y	N
Asthma	Y	N
Bursitis	Y	N
Cancer	Y	N
Depression	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Kidney Disease	Y	N
Poor circulation	Y	N
High Blood Pressure	Y	N
Rheumatoid Arthritis	Y	N
Stroke	Y	N

Other Conditions_____

Family History(Father, Mother or Sibling):
Circle one

Alzheimers	Y	N
Arthritis	Y	N
Asthma	Y	N
Cancer	Y	N
Cardiovascular Disease	Y	N
Diabetes	Y	N
Gout	Y	N
High Blood Pressure	Y	N
Stroke	Y	N
Thyroid Dysfunction	Y	N

Other:_____

Social History:

Do you smoke? Yes _____ No _____ Quit _____ How long ago did you quit?_____

Do you drink alcoholic beverages? Yes_____ No_____ Social_____

Do you do recreational drugs? Yes _____ No _____ If yes, what type?_____

Do you exercise? Yes _____ No _____ If yes, how often per week? _____

Vital Signs: Height:_____ Weight:_____

Surgical History:

List any procedures you have ever had(not just feet):_____

_____

Allergies:

None_____ Penicillin_____ Sulfa drugs_____ Iodine_____ Aspirin_____ Anesthetics_____

Latex_____ Codeine_____ Demerol_____ Darvocet_____ Morphine_____

Other:_____

Any other issues that you would like to discuss:_____
_____

SIGNATURE:_____DATE:_____

Name:______________________________ Date:______________

MEDICATIONS

Medication:	Dosage:	Frequency:	Purpose:	Prescribing Physician w/ Initial start date:
EXAMPLE: CHLORKEANTIN	500 mg.	1 tablet twice daily	Seizures	Dr. Jones Feb. 2010