CHEVY CHASE FOOT & ANKLE LLC

NEW PATIENT INFORMATION FORM

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BASIC INFORMATION (PLEASE PRINT)

NAME: _____ _____ _____
FIRST MI LAST

DATE OF BIRTH: ____/____/____

AGE AT VISIT: _____

SEX: ☐ MALE ☐ FEMALE ☐ OTHER: _____

SSN#: _____-_____-_____

HOME ADDRESS:_____
_____
_____

APT #: _____
CITY/STATE: _____
ZIP CODE: _____

PREFERRED PHONE NUMBER (CHECK ONE): MAY WE LEAVE A MESSAGE?

- ○ HOME PHONE #: (_____) _____-_____ YES NO
- ○ WORK PHONE #: (_____) _____-_____ YES NO
- ○ CELL PHONE #: (_____) _____-_____ YES NO

E-MAIL: _____@_____ YES NO

OTHER INFORMATION

RACE: ☐ AMERICAN INDIAN ☐ ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN
☐ WHITE ☐ HISPANIC ☐ OTHER _____ ☐ UNREPORTED/REFUSE TO REPORT

ETHNICITY: _____
PRIMARY LANGUAGE: _____
DO YOU NEED AN INTERPRETOR? ☐ YES ☐ NO

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES: NAME: _____ RELATIONSHIP: _____
PHONE #: (_____) _____-_____ DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)? ☐ YES ☐ NO

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

PHARMACY INFORMATION

DO YOU GIVE PERMISSION FOR US TO ACCESS YOUR PRESCRIPTION HISTORY? ☐ YES ☐ NO

PHARMACY (CHECK ONE):

- o CVS
- o WALGREENS
- o SAFEWAY
- o OTHER: _____

ADDRESS: _____ PHONE #: (_____) _____-_____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____
FAX #: (_____) _____-_____ PHONE #: (_____) _____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
☐ YES NAME(S): _____ ☐ NO
WHO IS RESPONSIBLE FOR PAYMENT? _____
RELATIONSHIP TO PATIENT? _____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____
PHONE #: (_____) _____-_____
WHO REFERRED YOU TO US?

- o PRIMARY CARE PROVIDER (PCP)
- o ENDOCRINOLOGIST
- o SOCIAL MEDIA
- o FRIEND/FAMILY
- o OTHER: _____
- o

INSURANCE INFORMATION (FOR OFFICE USE ONLY)

PRIMARY INSURANCE COMPANY NAME: _____	SECONDARY INSURANCE COMPANY NAME: _____
COPAY:	COPAY:
DEDUCTIBLE:	DEDUCTIBLE:
COINSURANCE:	COINSURANCE:
DME?	DME?

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

SOCIAL HISTORY

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

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE
☐ HISTORY OF ALCOHOL ABUSE ☐ CURRENT USE ☐ RARELY ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FREQUENCY: AVERAGE _____ DRINKS PER WEEK

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

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

HOW MUCH ARE YOU ON YOUR FEET DURING THE DAY? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EMPLOYER: _____
OCCUPATION: _____

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

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

TYPES OF EXERCISE:

_____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

MEDICAL HISTORY

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

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

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

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

NAME DOSE HOW OFTEN DO YOU TAKE THIS MEDICATION?

_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE

_____
_____
_____
_____

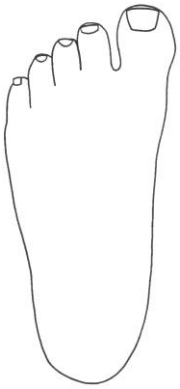
PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

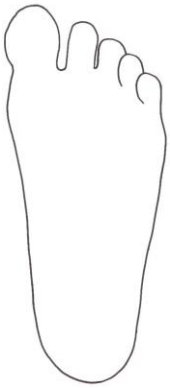
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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

LEFT FOOT



TOP OF FOOT

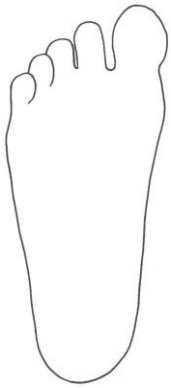


BOTTOM OF FOOT

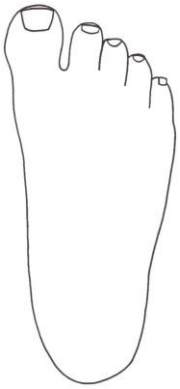
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

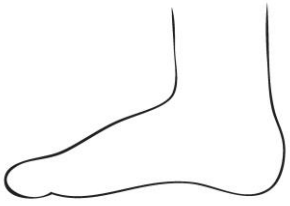


BOTTOM OF FOOT



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 ☐ N/A
☐ OTHER _____

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

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

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?

☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS
☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ N/A ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? (ICE, COMPRESSION, MEDICATION)

_____

HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

☐ YES ☐ NO

WAS THIS PROBLEM CAUSED BY AN INJURY?

☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

PATIENT CONSENT FOR TREATMENT

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

_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____
DATE