Welcome to Gig Harbor Foot and Ankle Clinic!!

Please complete:

Patient Name _____ M.I. _____
Mailing Address_____
City _____ Zip _____

Home Phone _____ Work Phone_____
Cell Phone _____ E-mail address _____

Sex: M F Date of Birth ____/____/_____ Marital Status: S M D W

Name **of referring physician**_____
Primary care physician _____ Phone _____
Date last seen _____ Fax _____

Emergency contact
Name _____ Relationship_____
Address _____ Phone_____

INSURANCE INFORMATION:

Name of Insurance Co: _____
ID Number_____
Group Number_____
Insurance information **if the main subscriber is other than the patient (Spouse or Parent)**
Primary Name on Card_____
Date of Birth _____ SS#: _____
Employer _____
Address_____Telephone:_____

Secondary Insurance_____
ID Number_____
Group Number_____

I hereby give my permission for the doctor to render the proposed Podiatric examination and treatment. I understand that I am financially responsible to the physician for all charges incurred by my dependents or me. I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the physician supplying the service.

Signature _____ Circle One: Self Parent POA

Date _____

Are you presently under a physician's or specialist's care? [ ] Yes [ ] No
Name of Physician: _____ Primary Reason: _____

FOOT HEALTH INFORMATION

What is your foot or ankle concern?

_____

When did it begin? _____? Was it due to an injury? Y N
If so, describe what happened: _____
What aggravates it? _____
Is it improving or worsening? _____
How have you treated the problem so far? _____
Have you seen a foot doctor before? _____ If so when? _____
Was this problem caused by an accident? Y N If so, when? _____
Was this a work related injury? _____ If so, where_____
Shoe size_____ Shoe Type: _____Height:_____Weight: _____
On a scale of 1 – 10 (10 being the worst), rate your pain level: _____

Are you allergic or do you have any reaction (sensitivity) to medications, tape, chemicals or food?

Medication	**Reaction**

Please List All Surgeries You Have Had:

Type	**Hospital**	**Date or Age**	**Physician**

Medications you are taking:	**Dose (mg.)**	**Times per day**	**Date Began**	**Date Stopped**

Please list hospitalizations:

Reason for Hospitalization	**Admission Date**	**Treating Physician or Hospital**

Habits and Social History:	Yes	No	Amount	Frequency	Years Used
Tobacco	___	___	_____	_____	
Alcohol	___	___	_____	_____	
Coffee or Tea	___	___	_____	_____	
Recreational Drugs	___	___	_____	_____	

Family History	**Yes**	**No**	**Family Member**
Cancer	___	___	_____
Diabetes	___	___	_____
High blood pressure	___	___	_____
Heart Disease	___	___	_____ (continued next page)
Kidney Disease	___	___	_____
Kidney Stones	___	___	_____
Other Family			

Mother: Alive __ Age: ____ Deceased____ at age_____ Cause of death _____ _
Father: Alive __ Age: ____ Deceased____ at age_____ Cause of\death:_____

Have you had any of the following medical conditions or occurrences? Check all that apply:

Cardiovascular (heart & blood vessels)

___ Heart attack
___ Chest pains (angina)
___ Abnormal heart rhythm/arrhythmia
___ High blood pressure
___ Elevated Cholesterol
___ Aneurysm
___ Phlebitis (blood clot)
___ Swelling of ankles/legs
___ Shortness of breath with activity
___ Shortness of breath with lying flat

Pulmonary (lungs)

___ Pneumonia
___ Asthma
___ Emphysema
___ Chronic Bronchitis
___ Cancer
___ Wheezing
___ Shortness of breath
___ Chronic cough

Gastrointestinal (intestines)

___ Hepatitis: type A, B, C, or D?
___ Cirrhosis ____Yellow jaundice
___ Stomach ulcers
___ Reflux
___ Colitis or enteritis

Endocrine (hormones)

___ Hypothyroid (low thyroid)
___ Hyperthyroid (high thyroid)
___ Diabetes – Diagnosed by _____ Date _____
___ Calcium disorder
___ Adrenal disorder
___ Heat or cold sensitivity
___ Frequent Urination

Blood &Lymphatic

___ Anemia
___ Bleeding disorder
___ Cancer – Where?_____
___ Polycythemia
___ Sickle Cell disease
___ Lymphoma /leukemia / multiple myeloma (circle on of the above)
___ Easy bruising
___ Enlarged lymph glands

Neurologic

___ Stroke-Weakness on R or L? ____
___ Spinal cord injury – Area Affected: _____
___ Seizures – Type_____
___ Migraine or frequent headaches
___ Vertigo (dizzy spells)

___ Diverticulitis
___ Nausea/ Vomiting
___ Pain in abdomen
___ Cancer

___ Gallbladder disease or stones
___ Pancreatitis
___ Blood in stool
___ Constipation

Renal (kidney)
___ Kidney failure
___ Dialysis
___ Cancer
___ Cysts

Musculoskelatal
___ Back injury
___ Herniated disc
___ Arthritis
___ Bone disease
___ Joint pain _____Stiffness
___ Fractures (broken bones)

___ Osteoporosis
___ Muscle disease
___ Gout
___ Rheumatoid arthritis

Skin
___ Lumps or bumps-Where_____
___ Rashes – Type_____
Where:_____
___ Open sores – Where _____
How long? __Treatment: _____
___ Psoriasis

___ Loss of consciousness
___ Confusion or memory loss
___ Neuropathy
Diagnosed by _____
Date _____

Head & Eyes
___ Sinus infections/problems
___ Hay fever
___ Nose bleeds
___ Glaucoma
___ Macular degeneration
___ Vision problems
___ Deafness
___ Ear infections

Infections and Immune Related Issues
___ AIDS
___ Chronic fatigue syndrome
___ Fibromyalgia
___ Itching ____ Hives _____
___ Arthritis – Type_____
Joints affected _____

Psychiatric
___ Depression
___ Anxiety disorder
___ Eating disorder

General
____ Weight gain /loss
____ Fever/ chills
____ Sweating at night
____ Decreased strength/vitality

Thank you!