SOUTH TEXAS FOOT SPECIALIST

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2016 UPDATE

Patient Name: _____ DOB: _____

SSN: _____ Email Address: _____

Address: _____

City: _____ TX Zip Code: _____

Phone No: _____

Current Medical Insurance Company: _____
ID Number: _____
Group Number: _____
Customer Service Phone Number: _____
Subscriber/Policyholder: _____

Please list the pharmacy where your prescriptions are filled:

Pharmacy: _____

Address: _____

Phone Number: _____

- o I have read and understand the Financial Policy for South Texas Foot Specialist
- o I have been notified of the HIPAA Notice of Privacy Practice

Patient/Guardian Signature: _____

Date: _____

SOUTH TEXAS FOOT SPECIALIST

Patient Medical History

CHIEF COMPLAINT

Current Complaint: _____ Duration: _____

Have you been treated for this before? Y N If so, when? _____ Was this an accident? Y N

If yes, date of accident/injury: _____ Place: _____

Brief description of accident/injury: _____

SOCIAL HISTORY

Tobacco: Y N Frequency: _____ Caffeine Y N Type: _____ Alcohol Y N Frequency: _____

MEDICAL HISTORY (Do you currently have or have had the following medical conditions)

- o ADD/ADHD
- o Allergies/Hay Fever
- o Anemia/Sickle Cell
- o Arthritis
- o Asthma/Bronchitis
- o Bleeding Disorders
- o Cancer Type: _____
- o Charcot Foot
- o Chest Pain
- o Crohn's Disease
- o Circulation Problems
- o Depression/Anxiety
- o Diabetes Type 1 Type 2
- o Difficulty Healing
- o Epilepsy/Seizures
- o Fibromyalgia
- o Graves Disease
- o Gout
- o Headaches
- o Heart Disease/Heart Attack
- o Hepatitis A, B, C
- o High Blood Pressure
- o Immune Disease (HIV, AIDS)
- o Kidney Stones
- o Liver Disease
- o Mitral Valve Prolapse
- o PVD
- o RSD
- o Shortness of Breath
- o Stroke
- o Thyroid Disease
- o Warts

List any other medical problem not listed above: _____

FEMALES: Are you or might you be pregnant? Y N Have you had a hysterectomy: Y N

Diabetic Doctor/PCP: _____ Phone: _____ Date Last Seen: _____

MEDICATIONS (Please include dosage of each. Include vitamins and supplements)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

ALLERGIES: (Aspirin, sulfa drugs, Penicillin, Iodine, Novocain, latex, foods, etc)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Have you ever had a reaction to local or general anesthesia? Y N

SURGERIES AND HOSPITALIZATIONS: (describe procedure, year and any complications)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

FAMILY HISTORY: (Please list any pertinent medical history such as diabetes, cancer, high blood pressure, etc)

Mother: Alive Deceased _____

Father: Alive Deceased _____

I hereby give South Texas Foot Specialist permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

_____ _____

Patient/Parent/Guardian Signature Date