MEDICAL FORM

MEDICAL FORM

FAMILY FOOT CENTRE

PATIENT INFORMATION

Part One

Name | **D.O.B.** Day / Month / Year | **Chart No.**

Sex ◉ M ○ F **Status** ◉ Single ◉ Married ○ Widowed ○ Divorced

Email | **Phone** Home / Mobile | **NIB**

Address | **Island** | **P.O. Box**

Emergency Contact Name | **Relationship Spouse/Partner**

Employer | **Address** | **Phone**

INSURANCE INFORMATION

Primary Insurance ◉ Y ○ N **Insurance Company** | **Owner of Policy**

Policy Number | **Group ID** | **Employer**

Relationship to Insured ◉ Self ○ Spouse ○ Child **Phone** | **Address**

Secondary Insurance ◉ Y ○ N **Insurance Company** | **Owner of Policy**

Policy Number | **Group ID** | **Employer**

Relationship to Insured ◉ Self ○ Spouse ○ Child **Phone** | **Address**

REASON FOR VISIT

Reason For Visit

Duration of Issue Years / Months / Weeks / Days

Cause ○ Accident ○ Work Injury ◉ Unknown

Pain Level on a of Scale 1 – 10 (1 being no pain and 10 being worst pain)

Describe Treatment Tried

Describe Type of Pain Burning

e.g. burning | sharp | shooting | tingling | dull

Please Read & Sign The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information herein.

Patient Signature | **Date**

Reviewed By To be reviewed by Family Foot Centre Staff.

MEDICAL FORM

FAMILY FOOT CENTRE

MEDICAL HISTORY

Part Two

Name _____ **D. O. B.** Day _____ Month _____ Year _____

Medical History

☐ Lupus	☐ Blood Disorders	☐ Circulation Problem	☐ Musculoskeletal	☐ Liver Disease
☐ Sickle Cell	☐ Gout	☐ Allergies	☐ Heart Disease	☐ Anxiety Disorder
☐ Heart Murmur	☐ Depression	☐ Asthma	☐ Mental Illness	☐ Stomach/Bowel
☐ Kidney Disease	☐ Blood Clot	☐ High Cholesterol	☐ Cancer	☐ High Blood Pressure
☐ Hepatitis	☐ Skin Disorders	☐ CVA/Stroke	☐ HIV	☐ Diabetes (Type 1 | Type 2)

☐ Arthritis _____ Specify

☐ Neuropathy _____ Specify

☐ Thyroid Disease _____ Specify

☐ Other _____ Specify

Are You Pregnant? ◯ Yes ◉ No

Are You Breast Feeding? ◉ Yes ◯ No

Surgical History ☐ None

Have you ever had any surgical procedure on foot/ankle or anywhere else on your body? ◉ Yes ◯ No

If yes, please state where _____

CURRENT MEDICATIONS

Current Medications ◉ I don't take medications ◯ I take the following medications

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Allergies to Medications ◉ No known allergies ◯ I have the following allergies to medication

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

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Patient Signature _____ **Date** _____

Reviewed By _____ To be reviewed by Family Foot Centre Staff.

MEDICAL FORM

FAMILY FOOT CENTRE

FAMILY HISTORY

Part Three

Is there any family (blood relative) history of: (*Please indicate family member*)

Alzheimer's		High Blood Pressure	
Arthritis		Diabetes	
Blood Clot		Heart Disease	
Cancer		High Cholesterol	
Cataracts / Glaucoma		Neurological	
Circulation Problems		Strokes	
Other (specify):		Other (specify):	

REVIEW OF SYSTEMS

Please check if you are currently experiencing any of these symptoms

Cardiovascular	none	fever	chest pain / pressure	leg swelling	cold hands / feet
	fainting	palpitations	vascular disease	valve problems	leg pain when walking
Genitourinary	none	hesitancy	incontinence	increased urgency	
	decreased frequency	excessive urination	kidney disease	kidney stones	blood in urine
Gastrointestinal	none	blood in stool	vomiting	constipation	diarrhea
	trouble swallowing	change in appetite	adominal pain		
Integumentary	athletes foot	nail abnormalities	ulcer / wounds	itchiness	dry / scaly skin
Hematological	none	sickle cell disease	anemia	blood thinners	lower leg ulcers
Neurological	tingling	weakness	seizures	numbness	headaches
Musculoskeletal	none	joint swelling	muscle weakness	muscle pain	neck pain
	sciatica	joint stiffness	arthritis	back pain	
Respiratory	none	wheezing	COPD	coughing	snoring
	shortness of breath	emphysema	chest pain		

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Patient Full Name **Patient Signature** **Date**

Reviewed By To be reviewed by Family Foot Centre Staff.

MEDICAL FORM

FAMILY FOOT CENTRE

PHARMACY AND PRIVACY INFORMATION

Part Four

Pharmacy Name

Pharmacy Phone

Pharmacy Address

Island, Area

Primary Care Physician

Phone

Address

Date Last Seen

Referring Physician

Phone

Address

Date Last Seen

Privacy

◉ Yes ○ No Can we call the phone number on file?

◉ Yes ○ No Can we send mail to the address on file?

◉ Yes ○ No Can we leave voicemail, text, or send WhatsApp to mobile number on file?

◉ Yes ○ No Can we send email reminder and educational newsletters?

If yes to email – please provide your email address

SOCIAL HISTORY

Do you smoke? ◉ Yes ○ No **If yes, please specify** Tobacco Marijuana

If yes, how many packs per day? For how long?

Do you drink alcohol? ◉ Yes, everyday (5-7 days/week) ○ Yes, occasionally/socially ○ Rarely ○ No

Substance abuse? ☐ Yes, I currently have a substance abuse problem Please specify

Occupation involves mostly ◉ Standing ○ Sitting

Type of exercise? ☐ None ☐ Walking ☐ Running ☐ Dancing ☐ Other

How often? ◉ Daily ○ Weekly ○ Occas.

Please Read & Sign

☑ **I willingly give consent for me / my dependent (please circle correct option) to receive health care services at Family Foot Centre.**

☑ I authorize the release of any medical information necessary to determine insurance benefits and process this claim. I also authorize payment of medical benefits to Family Foot Centre for services received **or**

☐ I have no insurance; therefore, I am responsible for payment in full at the time of my office visit.

Patient Full Name

Patient Signature

Date

Reviewed By

To be reviewed by Family Foot Centre Staff.