MEDICAL FORM

FAMILY FOOT CENTRE

PATIENT INFORMATION

Part One

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

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

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

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

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

Emergency Contact Name | **Phone** | **Relationship**

INSURANCE INFORMATION

Do you have Insurance? No Y **Owner of Policy** **Myself** | **Employer of Policy Owner**

Insurance Company | **Policy Number** | **Group ID**

Relationship to Insured Self Spouse Child **Date of Birth** | **Phone**

Secondary Insurance Y N **Owner of Policy** **Myself** | **Employer of Policy Owner**

Insurance Company | **Policy Number** | **Group ID**

Relationship to Insured Self Spouse Child **Date of Birth** | **Phone**

REASON FOR VISIT

Reason For Visit

How Long Have you had the issue? Years Months Weeks Days

Cause Accident Work Injury Unknown

Pain Level on a of Scale 1 – 10 (0 is no pain and 10 being worst pain)

Describe Type of Pain

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

Describe Treatments Tried None

Patient's Initial

Reviewed By

MEDICAL FORM

FAMILY FOOT CENTRE

MEDICAL HISTORY

Part Two

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

Medical History

- ☐ None
- ☐ 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
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Skin Disorders
- ☐ CVA/Stroke
- ☐ HIV
- ☐ Diabetes (Type 1 | Type 2)
- ☐ Arthritis _____ Specify Type
- ☐ Lupus
- ☐ Ulcers/Wounds
- ☐ Neuropathy
- ☐ Cancer _____ Specify Type
- ☐ Other _____ Specify

Are You Pregnant? ☐ Yes ☐ No

Are You Breast Feeding? ☐ Yes ☐ No

SURGICAL HISTORY

Surgical History

Have you ever had Surgery? ☐ Yes ☐ No

If yes, please state where on your body. _____

Have you ever had surgery on your foot or ankle? ☐ Yes ☐ No _____

CURRENT MEDICATIONS

Current Medications ☐ I don't take medications ☐ I take the following medications

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Allergies to Medications ☐ No known allergies ☐ I have the following allergies to medication

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Patient Initial _____ **Reviewed By** _____

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 (Heart)	☐ None	☐ fever	☐ chest pain / pressure	☐ leg swelling	☐ cold hands / feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ leg pain when walking
Genitourinary (Urine)	☐ None	☐ hesitancy	☐ incontinence	☐ increased urgency	☐ blood in urine
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	
Gastrointestinal (Digestive)	☐ None	☐ blood in stool	☐ vomiting	☐ constipation	☐ diarrhea
	☐ trouble swallowing	☐ change in appetite	☐ abdominal pain		
Integumentary (Skin)	☐ None	☐ nail abnormalities	☐ ulcer / wounds	☐ athletes' foot	☐ dry / scaly skin
Hematological (Blood)	☐ None	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ lower leg ulcers
Neurological (Nerves)	☐ None	☐ weakness	☐ seizures	☐ Numbness / Tingling	☐ headaches
Musculoskeletal (Muscles & bones)	☐ None	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ arthritis	☐ back pain	
Respiratory (Beathing)	☐ None	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema	☐ chest pain		

Patient Initial ☐

Reviewed By ☐

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?

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes **If yes, please specify.** ☐ Tobacco/ Vaping ☐ Marijuana

If yes, how many per day? ☐ # Joints / Cigarettes ☐ # Packs **For how long?** ☐ Months ☐ Years **Do you use recreational drugs?** ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes **How Often?** ☐ Rarely ☐ Occasional ☐ Social ☐ Daily **How many per day?**

Employment *Please circle* Student Unemployed Retired Employed **Occupation**

Occupation involves mostly ☐ Standing ☐ Sitting

Type of exercise? ☐ None ☐ Walking ☐ Running ☐ Other **How often?** ☐ Daily ☐ Weekly ☐ Occasional

Please Read, Check and 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 changes or updates to this information.

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

☐ I have insurance and 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.