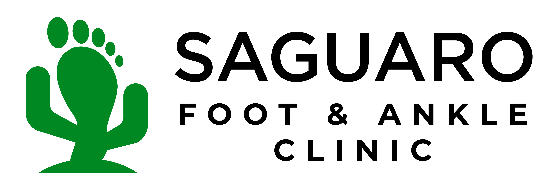
**PATIENT INFORMATION SHEET**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* Primary Care Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M/F Ethnicity\_\_\_\_\_ Marital Status Div/M/S/Wid**

**How did you hear about us?** □PCP- □Mailout Flyer- □Friend- □Insurance- □Facebook □Google- □Other\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip \_\_\_\_\_\_

Home Phone# ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone# ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**--------------------------------------------Patient’s Insurance Information------------------------------------**

**Primary Insurance Company Information Secondary Insurance Company Information**

Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Specialist Copay? Yes Amt$ \_\_\_\_ No Do you have a Specialist Copay? Yes Amt$\_\_\_ No

Policy Holder’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Yes No ---- If you have an interesting or educational foot/ankle problem, would you authorize Saguaro Foot & Ankle Clinic to post video and/or picture content of your foot condition to social media sites for educational purposes?***

**HIPAA DISCLOSURE/AUTHORIZATION TO RELEASE INFORMATION**: My signature below denotes my acceptance of

podiatric medical care. I authorize release of information to my referring physician or other providers as a necessary part of the course of medical diagnosis and treatment. Authorization is also given to release information to insurance companies necessary to the completion of insurance claims, review of services or receipt of benefits.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seen Previous Foot Specialist? Y / N If so, Name of doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tell me about your pain**:

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 □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your pain on a scale from 1-10? (Circle Please)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time you pain or problem began, has it: □ Stayed the Same □ Became Worse □ Improved

What makes your pain or problem feel worse? □ Walking □ Running □ Standing □ Daily Activities □ Resting

□ Dress Shoes □ High Heels □ Flat Shoes □ Any Closed Toes Shoes □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain or problem feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatments have you had for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How has the problem affected your lifestyle or ability to work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was this problem caused by an injury? □ Yes (Describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No If yes, was it a work-related injury? □ Yes □ No

Where is the pain/problem located? Please mark on pictures below.

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

►Current Medications

□ None or See List Below (or attach list, if nec)

|  |  |  |
| --- | --- | --- |
| Medication Name | Dose (mg, units, etc) | How Often/When |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

►Patient Medical History

Have you been diagnosed with any of the following? Please circle all that apply:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Anemia |  |  |  | Liver Disease |
|  | Arthritis | Gout |  |  | Sleep Apnea |
|  | Asthma | Heart Attack |  |  | Stroke |
|  | Back Problems | High Blood Pressure |  |  | Stomach Disorders |
|  | Blood Clots | HIV/AIDS |  |  | Ulcers/Reflux |
|  | Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Heart Disease |  |  | Thyroid Disorder |
|  | Depression | Hepatitis A/B/C |  |  | Tuberculosis |
|  | **Diabetes 1 Yes No** | High Cholesterol |  |  | Parkinsons |
|  | **Diabetes II Yes No** | Irregular Heartbeat |  |  | Cerebral Palsy |
|  | **Are you taking insulin? Yes No** | Kidney Stones |  |  | Dementia |
|  | Emphysema | Kidney Disease |  |  | Osteoarthritis |
|  | Fibromyalgia | Rheumatoid Arthritis | | |  |
|  |  |  | | |  |
| ►Previous foot/ankle Surgeries □ None or | | Please list procedure and date performed | | |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

► Family History

□ Stroke □ Arthritis □ Cancer □ Diabetes □ Heart Disease □ High Blood Pressure

►Social History

* Use of Alcohol? □ No □ Yes (If yes, how much/frequently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Use of Tobacco? □ No □ Yes (If yes, how much/frequently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

►Review of Systems

Please check all conditions and symptoms that you currently have:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| General: | \_\_Fever | | \_\_Fatigue | \_\_Sleeping Problems | \_\_Weight loss/gain |
| Skin: | \_\_Rash | | \_\_Itching | \_\_Lesions/Sores | \_\_Dry skin |
| Heart: | \_\_Chest pain | |  | \_\_Irreg heart beat | \_\_Murmur |
| Musculoskeletal: | \_\_Joint pain |  | \_\_Muscle weakness | \_\_Joint Stiffness | \_\_Palpitations |
| Neurological: | \_\_Numbness |  | \_\_Seizures | \_\_Dizziness | \_\_Deformity |
| Endocrine: | \_\_Diabetes |  | \_\_Thyroid | \_\_Excessive Sweating | \_\_Weakness |

►Vitals

Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shoe Size\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature (Parent or Guardian if patient under 18 years old) Date:

Witness’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_