

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home # () _____ Cell # () _____ Work # () _____

Emergency Contact: _____ Phone: () _____ Relationship: _____

E-Mail: _____ Gender: Male Female X

Please list your preferred pronouns for how you'd like to be addressed (i.e. he/him/his): _____

Family Physician: _____ Phone Number: () _____

Fax Number: () _____

Birth Date: ____/____/____ Marital Status: Single Married Widowed Divorced

Employer: _____ Employer Address: _____

__FULL TIME__PART TIME __NOT EMPLOYED __SELF-EMPLOYED __RETIRED __ACTIVE MILITARY DUTY __STUDENT

Pharmacy: _____ Pharmacy Phone Number: () _____

HOW DID YOU HEAR ABOUT US: Doctor Referral Insurance Friend/Family Internet/Google

Referred by: _____ Other: _____

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

| Name | Phone Number | Relationship |
|-------|--------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____ to pay and hereby assign directly to District Podiatry, PLLC all benefits. I further acknowledge that any insurance benefits, when received by and paid to District Podiatry, PLLC will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date:** _____

SOCIAL HISTORY

Do or Did you smoke cigarettes? Yes No If Yes, packs per day? _____ Stop date: _____

Drink alcohol regularly? Yes No Do you exercise regularly? Yes No

Allergies to any medication? Yes No If Yes, which medications? _____

Place of Birth? _____ Unusual Occupational Exposures? _____

Please list ALL medications you are currently taking: _____

MEDICAL HISTORY:

Previous Surgery/Hospitalizations _____

Blood Transfusions (dates): _____ General Anesthesia: _____

Injuries and Fractures (types & dates): _____

FAMILY HISTORY (check if anyone in your family has had or had the following)

| | MOTHER | FATHER | SILBINGS | CHILDREN | OTHER RELATIVE |
|-----------------|--------|--------|----------|----------|----------------|
| CANCER | | | | | |
| DIABETES | | | | | |
| HEART DISEASE | | | | | |
| ARTHRITIS | | | | | |
| OSTEOPOROSIS | | | | | |
| AGE (IF LIVING) | | | | | |

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

| | YES | NO | | YES | NO |
|--------------------------------|-----|----|---------------------------------|-----|----|
| Chronic Headaches/Migraines | | | Diabetes | | |
| Dizziness | | | High Blood Pressure | | |
| Fainting Spells/Blackouts | | | High Cholesterol | | |
| Eye Disease/Glaucoma/Cataracts | | | Joint Pains/Swelling | | |
| Double Vision | | | Swelling of ___ Feet ___ Ankles | | |
| Recent Vision Impairment | | | Numbness/Tingling of hand/Feet | | |
| Impaired Hearing | | | Color Changes in the Hands | | |
| Ringing in the Ears | | | Chest Pressure/Chest Pain | | |
| Dryness of ___ Eyes ___ Mouth | | | Chronic Back Pain | | |
| Recent Hair Loss | | | Chronic Neck Pain | | |
| Asthma | | | Parkinsonism | | |
| Recurrent Fever | | | Osteoporosis | | |
| Thyroid Disorder | | | Sciatica | | |
| Pneumonia | | | Anemia or Blood Disorder | | |
| Pleurisy | | | Skin Rash | | |
| Frequent Cough | | | Psoriasis | | |
| Tuberculosis Exposure | | | Recent Weight ___ Gain ___ Loss | | |
| Difficulty Breathing | | | Loss of Appetite | | |
| Coughing Up Blood | | | Constant Thirst or Hunger | | |
| Rheumatic Fever | | | Stomach/Duodenal Ulcer | | |
| Difficulty Urinating | | | Abdominal Pain/Heart Burn | | |
| Painful/frequent Urination | | | Frequent Nausea/Vomiting | | |
| Blood in Urine | | | Heart Murmur | | |
| Nighttime Urination ___ Times | | | Cancer | | |
| Prostate Disorder | | | Palpitations | | |
| Recurring Bladder Infections | | | Convulsions OR Epilepsy | | |
| Kidney Disease/Stones | | | Hepatitis/Jaundice | | |
| Pancreatitis | | | HIV Virus Positive | | |
| Diverticulitis | | | Chronic Anxiety | | |
| Phlebitis | | | Depression | | |
| Insomnia | | | | | |

Date of: Most Recent Medical Exam _____

EKG _____ Blood Tests _____ Chest X-Ray _____

Reason for office visit today: _____