

**CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
ANNUAL UPDATE**

Patient Name: _____

Appointment Date: _____

Referring Physician (Name & Practice Location): _____

Preferred Pharmacy & Location: _____

1. Describe your foot/ankle problem(s) (including left, right or both) :

2. How long have you had this problem? _____

3. Are you experiencing pain? No Yes (if yes, please answer the following)

How long have you had pain? _____ days _____ weeks _____ months _____ years

Describe the type of foot pain: Burning Aching Sharp Stabbing Throbbing Pins/Needles Numb

Pain severity 0 = none, 10 = very severe (please circle) 0 1 2 3 4 5 6 7 8 9 10

Exact location (if possible): _____

How frequent is the pain? Constant Most of the day A few times per day Weekly

Pain is often experienced with: Walking/Standing Resting Certain Shoes Pressure With Activity

The pain is made worse by: _____

Do you feel numbness in your feet? Yes No Tingling? Yes No

Social History

4. If female, are you currently pregnant? No Yes Maybe

5. Do you smoke cigarettes? No Yes If so, for how many years? _____ How many packs per day? _____

6. Are you a former smoker? No Yes If so, for how many years? _____ How many packs per day? _____

7. If you have diabetes, please answer the following questions:

Do you check your blood sugar at home? Yes No If so, how often? _____ Last result: _____

Last Hemoglobin A1C Value: _____ Date: _____ Drawn where? _____

Date of your last dilated eye exam: _____ Performed where? _____

Date of your last screening urine test: _____ Performed where? _____

PLEASE COMPLETE BOTH SIDES

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8. **Have you had any surgeries or hospitalizations in the past two years?** No Yes

If yes, please explain: _____

9. **Family History** (Who in your family has had these medical problems?): NONE

Diabetes _____ Heart Disease _____ Kidney Disease _____

Hypertension _____ Stroke _____ Mental Illness _____

Arthritis _____ Bleeding Disorder _____ Cancer _____

Other Family History: _____

10. **List all Medications/vitamins with dose & directions:** NONE I have attached a list

11. **Do you take the following?** Tylenol Advil, Ibuprofen, Aleve or Motrin

If so, how much? _____

How often? _____

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12. **Allergies** (If yes, what type of reaction?) NONE Latex _____
- Penicillin _____ Sulfa Drugs _____
- Other Antibiotics (which ones?) _____ Nickel/Other Metals _____
- Aspirin _____ Surgical Implants _____
- NSAIDS (Ibuprofen/Aleve): _____ X-ray Contrast Dye _____
- Pain Medication (which ones?): _____ Other _____

13. **FLU VACCINE** Have you received the flu vaccine this year? No Yes If yes, when? _____

14. **VITAMIN D LEVEL** Have you had your Vitamin D Level checked? Yes (normal abnormal) No Unsure

15. **Past Medical History:** (Check those that apply to you) NONE

<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Other Cancer (where?)	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> GERD
<input type="checkbox"/> Lung/Respiratory Disorders	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Past Heart Attack (when?)	Do you receive kidney dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	# Years:
<input type="checkbox"/> History of Blood Clots	<input type="checkbox"/> Gout
<input type="checkbox"/> Other Bleeding Disorders	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Other Arthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Depression or Mood Swings	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Neuropathy or Nerve Damage	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other:	<input type="checkbox"/> History of MRSA Infection

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Signature: X _____
Patient or Personal Representative

Date: _____

To be used by Carolina Foot & Ankle Staff:

BP (sitting): _____/_____ Pulse _____/min (Reg. Irreg.) Resp. _____/min Temp: _____°F

Height _____ Weight _____

**CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
DEMOGRAPHICS**

Patient's Last Name: _____ **First:** _____ **Middle Int:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Gender: _____ **Marital Status:** Single Married Widowed Divorced Legally Separated

Race: White Black Hispanic Asian Native American Other: _____

Ethnicity: Hispanic Non Hispanic **Preferred language:** _____

Social Security: _____ **Date of Birth:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Primary Care Doctor's Practice Name: _____

Email Address: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Who carries the insurance? The patient Other (Name): _____ **DOB:** _____

How did you hear about our practice? _____

Is the patient in a facility (ex: nursing home)? Name: _____ Phone: _____

Responsible Party

If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible Party's Name: _____ **Relationship to patient:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

In case of emergency, whom do we contact? _____

Home: _____ **Cell:** _____ **Work:** _____

I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

Signature: X _____
Patient or Personal Representative

Date: _____