

FOOT AND ANKLE CLINIC OF CENTRAL TEXAS

Patient Intake Form

We would like to welcome you to our practice. Please complete this form as accurately as possible so we can most appropriately address your healthcare needs.

The confidentiality of your health information is protected in accordance with federal protections for the health information under the Health Insurance Portability and Accountability Act (HIPAA).

Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing.

Please print all responses: Date: _____

Name: _____ Age: _____

Last First Middle

Date of Birth: _____ Sex: _____ Race: _____ Ethnicity: _____

Marital status: single married separated divorced widowed

Address: _____

Street City State Zip code

Phone contact: Primary: _____ Secondary: _____

Email: _____

Guarantor: _____

Social Security number: _____

Occupation: _____ Employer _____

Primary Insurance: _____ Policy: _____

Responsible party: _____ Date of birth: _____

Social Security number: _____

Provide foot or ankle problem: _____

Provide specific injury details including when and where: _____

Name and address of primary care physician: _____

Name and address of cardiologist(if applicable): _____

Who referred you to our office: _____

Do you experience chronic pain? Yes No

If yes how is your pain managed (ie, physical therapy, medication, etc)?

Surgeries:

Please list specific surgeries and dates

Patient Medical History:

Please check all that apply

- Heart Disease (type _____)
- Stroke (when _____)
- High Blood Pressure
- High Cholesterol
- Diabetes (type ____ how long ____)
- Venous Thrombosis
- AIDS
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Cirrhosis
- Anemia
- Thyroid Trouble
- Gallbladder Disease
- Ulcers (where) _____
- Cancer (type) _____
- Arthritis (type) _____
- Osteoporosis
- Fractures (where) _____
(when) _____
- Migraines
- Depression
- Anxiety or Panic Disorder
- Alcohol or Substance Use Problem
- Other: _____

Family Medical History

Please check all that apply	Relationship
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Arthritis (type)	_____
<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Migraine Headaches	_____
<input type="checkbox"/> Cancer(type)_____	_____

System Review

Please check any of the following symptoms that you have recently experienced

General

<input type="checkbox"/> Recent weight loss	<input type="checkbox"/> Recent weight gain	<input type="checkbox"/> fatigue
<input type="checkbox"/> fever	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> night sweats

Skin

<input type="checkbox"/> rashes	<input type="checkbox"/> lumps	<input type="checkbox"/> itches
<input type="checkbox"/> dryness	<input type="checkbox"/> color change	<input type="checkbox"/> hair/nail change

Cardiac

<input type="checkbox"/> Heart murmur	<input type="checkbox"/> chest pain	<input type="checkbox"/> palpitations
<input type="checkbox"/> swelling of feet	<input type="checkbox"/> shortness of breath	

Musculoskeletal:

<input type="checkbox"/> joint stiffness	<input type="checkbox"/> arthritis	<input type="checkbox"/> gout
<input type="checkbox"/> backache	<input type="checkbox"/> muscle pain	<input type="checkbox"/> muscle cramps

Peripheral Vascular

<input type="checkbox"/> leg cramps while walking	<input type="checkbox"/> varicose veins	<input type="checkbox"/> thrombophlebitis
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Neurological:

<input type="checkbox"/> fainting	<input type="checkbox"/> blackouts	<input type="checkbox"/> seizures
<input type="checkbox"/> weakness	<input type="checkbox"/> numbness	<input type="checkbox"/> tremors
<input type="checkbox"/> tingling hands/feet	<input type="checkbox"/> change in memory	

Psychiatric/Psychological

<input type="checkbox"/> anxiety	<input type="checkbox"/> depression	<input type="checkbox"/> phobias
<input type="checkbox"/> family problems	<input type="checkbox"/> eating disorder	

Hematologic

<input type="checkbox"/> anemia	<input type="checkbox"/> easy bruising or bleeding
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Endocrine:

<input type="checkbox"/> heat/cold intolerance	<input type="checkbox"/> excessive sweating	<input type="checkbox"/> excessive hunger
<input type="checkbox"/> excessive urinating		

Current Medications:

Pharmacy: _____

Please include any non-prescription drugs as well, eg, vitamins, aspirin, etc

Medication name	Dose	Frequency of use
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		
11. _____		
12. _____		
13. _____		
14. _____		
15. _____		
16. _____		
17. _____		
18. _____		
19. _____		
20. _____		

Allergies:

Please list any allergies and reactions you may have to medications.

Substance use history:

Use of alcohol:

never rarely moderate daily

Use of tobacco:

never current smoker former smoker _____

Other: _____

Do you have an advanced health directive, such as do not resuscitate? Yes No

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care for you.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to preform the necessary services I may need.

Guarantor signature: _____ Date: _____