KINGS FOOT AND ANKLE CENTER

REVIEW OF MEDICAL PROBLEMS PAST OR PRESENT

For all items below, please mark Yes (Y), No (N), OR (?) if unsure

YOUR NAME_____ **DATE OF BIRTH**_____

	Heart/Circulation	Comments		Endocrine	Comments
	Chest Pain/ Tightness			Thyroid disease	
	Heart Attack			Diabetes	
	Heart Surgery			Other	
	Congestive Heart failure			Blood	
	Heart Valve Disease/murmur			Anemia	
	Pacemaker/ Heart implant			**Infectious Disease**	
	High blood pressure			HIV	
	High cholesterol			Hepatitis	
	Stroke/ TIA			**Stomach/ Abdomen**	
	Blood vessel surgery			Indigestion, reflux	
	Blood clots/ bleeding problems			Liver disease	
	Lungs			Ulcers, hernias	
	Difficulty breathing/ asthma			Bloody/dark stool	
	Shortness of breath			**Bones/ Joints/Muscles**	
	Coughing up blood			Pain	
	Current/frequent cough			Arthritis	
	Sleep apnea/heavy snoring			Cane, brace, etc.	
	Nervous System			Joint replacement	
	Fainting/blackouts			Back or Neck Pain	
	Seizures			Injuries	
	Abnormal feeling			**Constitutional**	
	Rheumatic Disease			Current fever/chills/nausea	
	Skin			Unexplained weight loss	
	Sores/ Rashes			Pain intensity 1-10	
	Sensitivity/ Allergy			**Ears/Nose/ Throat**	
	Genital/ Urinary			Any current problems	
	Dialysis			**Psychiatric**	
	Kidney Disease			Depression, Anxiety, Other	
	Gynecologic			**Cancer**	
	Pregnant or possibly pregnant			Current or past	
	Breastfeeding			Radiation	
	Last menstrual date			Chemotherapy	
	Walking/ balancing problems			Type and Location	
	History of falls			**Miscellaneous**	

I certify by my signature that the above noted medical history is complete, accurate, and current to the best of my knowledge.

Signature of Patient/Guardian:_____ Date:_____ Physician Initial:_____

KINGS FOOT AND ANKLE CENTER

MEDICAL HISTORY FORM (Please fill out completely)

YOUR NAME_____ **DATE OF BIRTH**_____

REASON FOR SEEING DOCTOR TODAY_____

PAIN INTENSITY: RATE 0 TO 10_____

CURRENT MEDICATIONS_____

ALLERGIES: Are you allergic to any medications? ☐ No ☐ Yes (please specify below)_____

LIST ANY TIME YOU HAVE STAYED IN A HOSPITAL AND ALSO ANY OPERATIONS PERFORMED ON YOU_____

WHAT MEDICAL CONDITIONS DO YOU SEE A DOCTOR FOR OR TAKE MEDICATIONS TO TREAT? _____

FAMILY MEDICAL HISTORY (briefly, what medical problems run in the family)? _____

PREVIOUS HISTORY OF FOOT, ANKLE, OR LEG PROBLEMS_____

SMOKING/TOBACCO ☐ No ☐ Yes_____Pack/day

ALCOHOL INTAKE_____

WORK DESCRIPTION_____

RECREATIONAL ACTIVITY_____

LIVING SITUATION (alone, or with assistance?)_____

SHOE SIZE_____ **APPROXIMATE HEIGHT** _____**WEIGHT**_____

I certify by my signature that the above noted medical history is complete, accurate, and current to the best of my knowledge.

Signature of Patient/Guardian: _____ Date: _____ Physician Initial: _____

KINGS FOOT AND ANKLE CENTER

Patient Information Form (Please Print)

Personal Information

Patient's Name_____ Home Phone_____

Address_____ City_____ Zip_____

Birth Date_____ Age_____ ☐ Male ☐ Female Social Sec. #_____

Employer _____ Business Phone_____ Cell Phone_____

E-mail Address_____

Whom May We Contact in the Event of Emergency?

Name_____ Relationship_____ Phone #_____

Medical Insurance Information

☐ Check if Not Insured

Primary Insurance Co._____ Name of Insured_____

Insured Social Sec. #_____ Insured's Date of Birth_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer _____ Secondary Insurance Co._____

Referral Infomation

Primary Care Physician_____

Address_____ City_____ Zip_____

Referred by:

☐ Doctor_____ Address_____ City_____ Zip_____

☐ Patient or Friend (please list)_____

☐ Preferred Provider (PPO) Directory ☐ Phone Book/Yellow Pages

☐ Internet _____ ☐ Other (please list)_____

Pharmacy Information

Pharmacy name, location, and phone #_____

_____

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and chargers for such treatment. I agree to pay charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Kings Foot and Ankle Center, Inc. of surgical, medical, and x ray benefits otherwise payable to me. I understand I am financially responsible for charges not covered.

Signature (patient or guardian)_____ Date_____