CORSICANA FOOT & ANKLE

# ORTHOPEDIC INTAKE FORM

## PATIENT INFORMATION

Last Name ____________ First Name ____________ MI ________ Sex ❒ M ❒ F

Date of Birth ____________ Age ________ Social Security # ____________

Address ____________ City ____________ Zip ________

Who can we thank for referring you/ how did you find us? ____________

Family Physician ____________ Date of Last Visit ____________

Pharmacy ____________ City ____________

Height ____________ Weight ____________ Shoe Size ____________

## PHONE NUMBERS

Home Phone ____________ Cell Phone ____________

Email ____________

In case of emergency, please contact:

Name ____________ Phone ____________

## EMPLOYMENT

Name of Employer ____________ City ____________

At your job do you: ❒ sit mostly ❒ stand mostly ❒ sit and stand

Are you required to wear a specific type of shoe/ boot? ____________

## REVIEW OF SYSTEMS Please check all that apply

| | |
|---|---|
| Nerve: | ❒ Foot Burning ❒ Foot Numbness ❒ Seizure ❒ Loss of Balance |
| Skin: | ❒ Rash ❒ Skin Sores ❒ Itching ❒ Dry Skin ❒ Toenail Changes |
| Orthopedic: | ❒ Joint Pain ❒ Muscle Pain ❒ Leg Cramps ❒ Weakness ❒ Knee Pain ❒ Back Pain |

## REASON FOR VISIT

Reason for today's visit ______________________________ How Long? ______________

Severity of Pain or condition ❒ Mild ❒ Moderate ❒ Severe ❒ Severe at times

Type of pain (if painful) ❒ Sharp ❒ Dull ❒ Stabbing ❒ Aching ❒ Burning ❒ Other ________

This problem is ❒ Improving ❒ Worsening ❒ Unchanged

What makes it worse ❒ Activity ❒ Exercise ❒ Work ❒ Laying in Bed ❒ Other ________

What makes it better ❒ Rest ❒ Ice ❒ Heat ❒ Elevation ❒ Other ________________

What treatments have you tried, if any? ________________________________________

## MEDICAL HISTORY Please check the ones that apply

❒ AIDS / HIV
❒ Diabetes (Insulin)
❒ Diabetes (No Insulin)
❒ Arthritis
❒ High Blood Pressure
❒ Stroke (CVA)
❒ Heart Trouble
❒ Kidney Disease
❒ Lung Disease (COPD)
❒ Hepatitis (A, B, C)
❒ Stomach Problems
❒ Anxiety / Depression
❒ Gout
❒ Fibromyalisia
❒ Blood Clots
❒ Artificial Joints
❒ Cancer: ________________

## FINANCIAL POLICY

*I give permission to Jeffrey S. Petty DPM, his associates or assistants to examine/treat me during the care of my condition. I understand that I am financially responsible for all charges, whether or not paid by insurance. The only limitation to my financial liability for charges not paid by insurance occurs in the event of contractual limitations to the charged fees that have been agreed upon by Jeffrey S. Petty, DPM, PA and the insurance company. I authorize use of this signature for all insurance claims (including Medicare/Medicaid if applicable).*

*Signature* ______________________________________ *Date* ______________________

## PFSH

Past Surgeries ____________________________________________________________

Do you smoke tobacco? ❒ Yes ❒ No If yes, how many packs per day? ____________

Do you drink alcohol? ❒ No ❒ Occasional ❒ Moderate ❒ Heavy

Circle all that apply. Family History of: Diabetes, Gout, Flat Feet, Ingrown Toenails, Bunions

## MEDICATIONS

____________________ Dosage ________ ____________________ Dosage ________

____________________ Dosage ________ ____________________ Dosage ________

____________________ Dosage ________ ____________________ Dosage ________

____________________ Dosage ________ ____________________ Dosage ________

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