

OREGON FOOT AND ANKLE SPECIALISTS

Patient Information Form

(Please Print)

Date: ___/___/___

Patient Name: _____ Date of Birth: ___/___/___ Age: ___ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

Mailing Address: _____ City/State: _____ Zip: _____

MAY WE LEAVE A MESSAGE?

Home Phone #: (____) _____ - _____ Yes No Social Security # _____

Cell Phone #: (____) _____ - _____ Yes No Drivers License # _____

Primary Language: _____

Do you have a legal guardian or healthcare power of attorney? Yes No

If yes, Name: _____ Relationship: _____ Phone #: (____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____ - _____

Primary Care Doctor: _____ Who referred you to us? _____

Pharmacy: _____ Location: _____ Phone #: (____) _____ - _____

Is there a family member or other person you would like for us to share your medical information?

___ Yes Name(s) _____

___ No

Who is responsible for payment? _____ Relationship to patient? _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) _____ - _____

INSURANCE INFORMATION

Primary Insurance Company name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) _____ - _____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____

Secondary Insurance Company name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) _____ - _____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____

Patient Name: _____

Please list all medications you are currently taking (include prescriptions, over-the-counter meds and herbal supplements):

Name	Dose	How often do you take?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all prior hospitalizations (other than for surgery):

Reason for Hospitalization	Date	Reason for Hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Marital Status: Single Married Partnered Separated Divorced Widowed

Use of Alcohol: Never No longer use History of alcohol abuse

Current use - type _____ Rare Occasional Moderate Daily

Use of Tobacco: Never Quit - how long ago? _____ Smoke _____ packs/day for _____ years

Use of recreational drugs: Never Quit - how long ago? _____ Type _____

Current use - type _____ Rare Occasional Moderate Daily

Employer: _____ Occupation: _____

How much are you on your feet during the day? 10% 25% 50% 75% 100%

Exercise: Never Rare Occasional Weekly Several times a week Daily

Types of exercise: _____

FAMILY HISTORY

Do you have a family history of: Diabetes Cancer Heart Disease High Blood Pressure

Stroke Coronary Artery Disease Thyroid Disease Rheumatoid Arthritis

Other _____

Patient Name: _____

Date of Birth: ____/____/____

YOUR MEDICAL HISTORY

Allergies: None Known Medications _____
 Anesthesia _____ Foods _____
 Tape Latex Shellfish Iodine Other _____

Have you ever had any of the following? If yes, please circle Current (C) or Past (P)

Acid Reflux	Y	N	C/P	Fibromyalgia	Y	N	C/P	Neuropathy	Y	N	C/P
Anemia	Y	N	C/P	Gout	Y	N	C/P	Open Sores	Y	N	C/P
Arthritis	Y	N	C/P	Heart Attack	Y	N	C/P	Pneumonia	Y	N	C/P
Asthma	Y	N	C/P	Heart Disease/Failure	Y	N	C/P	Polio	Y	N	C/P
Back Trouble	Y	N	C/P	Hepatitis	Y	N	C/P	Rheumatic Fever	Y	N	C/P
Bladder Infections	Y	N	C/P	HIV+/AIS	Y	N	C/P	Sickle Cell Disease	Y	N	C/P
Abnormal Bleeding	Y	N	C/P	High Blood Pressure	Y	N	C/P	Skin Disorder	Y	N	C/P
Blood Clots	Y	N	C/P	Kidney Disease	Y	N	C/P	Sleep Apnea	Y	N	C/P
Blood Transfusion	Y	N	C/P	Liver Disease	Y	N	C/P	Stomach Ulcers	Y	N	C/P
Bronchitis/Emphysema	Y	N	C/P	Low Blood Pressure	Y	N	C/P	Stroke	Y	N	C/P
Cancer	Y	N	C/P	Migraine Headaches	Y	N	C/P	Thyroid Disease	Y	N	C/P
Diabetes	Y	N	C/P	Mitral Valve Prolapse	Y	N	C/P	Tuberculosis	Y	N	C/P
Other Conditions: _____											

CURRENT PROBLEM

What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.

LEFT FOOT



Top of Foot



Bottom of Foot



Inside of Foot



Outside of Foot

RIGHT FOOT



Bottom of Foot



Top of Foot



Outside of Foot



Inside of Foot

Patient Name: _____

Date of Birth: ____/____/____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: Begin all of a sudden Gradually develop over time

How would you describe your pain? No Pain Sharp Dull Aching Burning

Radiating Itching Stabbing Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since the time your pain or problem began, has it: Stayed the same Become worse Improved

What makes your pain or problem feel worse? Walking Standing Daily Activities

Resting Dress Shoes High Heels Flat Shoes Any Closed Toe Shoe

Running Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? Yes (describe) _____ No

If yes, was it a work-related injury? Yes No

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.

Print Name of Patient, Parent or Guardian

Signature of Doctor

If Other than Patient, Relationship to Patient

Date

Signature

Date