PATIENT INFORMATION

NAME _____ SOC. SEC # _____

ADDRESS _____

BIRTH DATE _____ MARITAL STATUS _____ GENDER _____

PHONE _____ ALT. PHONE _____ WORK PHONE _____

EMAIL _____ REFERRED BY _____

EMERGENCY CONTACT _____ PHONE _____

EMPLOYER _____ OCCUPATION _____

PRIMARY INSURANCE _____ GUARANTOR _____

SECONDARY INSURANCE _____ GUARANTOR _____

PRIMARY DOCTOR _____ LAST SEEN? _____

IF PATIENT IS A MINOR COMPLETE THE SECTION BELOW

FATHER'S NAME _____ BIRTH DATE _____ SS# _____

PHONE _____ ALT PHONE _____ MARITAL STATUS _____

ADDRESS _____

MOTHER'S NAME _____ BIRTH DATE _____ SS# _____

PHONE _____ ALT PHONE _____ MARITAL STATUS _____

ADDRESS _____

LEGAL GUARDIAN _____

PATIENT AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I, _____, understand that pursuant to Texas law, my medical condition is confidential. For my physician and staff to discuss my medical conditions with family or friends, I understand that I must give written authorization. I understand I may revoke this authorization at any time by submitting a written order to Family Foot and Ankle Specialists. Therefore, I authorize Family Foot and Ankle Specialists the authority to discuss my medical condition with the following individuals.

1._____ 2._____

3._____ 4._____

5._____ 6._____

HISTORY: PLEASE CIRCLE ALL APPLICABLE INFORMATION

CHILDHOOD: UNREMARKABLE, Rheumatic Fever, Polio, Cerebral Palsy, Bleeding Disorders, Musculoskeletal Disorders, Diabetes

ADULT: UNREMARKABLE, High Blood Pressure, Chest Pain, Shortness of Breath, Heart Disease, Circulatory Disorders, Diabetes, Gout, Arthritis, Seizures, Lung Problems, Kidney Disorders, Liver Disease, HIV, Ulcers, Thyroid Disease, Stroke, Cancer, Epilepsy, Tuberculosis, Chemical Dependency, Ankle Swelling

FAMILY: UNKNOWN, Hypertension, Coronary Artery Disease, Diabetes, Gout, Arthritis, Asthma, Emphysema, Glaucoma, Stroke, Cancer, Epilepsy, Bleeding Disorders, Kidney Disease, Thyroid Disease, Mental Illness, Osteoporosis, Birth Defects, Tuberculosis, Alcoholism, Sickle Cell.

SOCIAL HISTORY

LIVE WITH: _____CAFFEINE: _____ALCOHOL _____DIET _____

TOBACCO USE: NON-SMOKER SMOKES _____Pack(s) a day. SMOKELESS TOBACCO _____

FORMER SMOKER: QUIT _____YEARS AGO SMOKED _____YEARS ILLICIT DRUG USE _____

HEIGHT _____WEIGHT _____SHOE SIZE ____PHARMACY _____CITY _____

DRUG ALLERGIES: NO KNOWN ALLERGIES, Penicillin, Sulfa, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia OTHER: _____

MEDICATIONS (INCLUDE DOSING IF POSSIBLE):

1._____6. _____11. _____

2._____7. _____12. _____

3._____8. _____13._____

4._____9. _____14. _____

5._____10. _____15. _____

HEALTH INFORMATION

CURRENT PROBLEMS _____DURATION _____

CAUSED BY _____RELIEVED BY _____

AGGRAVATED BY _____PRIOR TREATMENT _____

WAS THIS AN ACCIDENT? _____AT WORK? _____WERE THEY NOTIFIED? _____

ARE YOU DIABETIC? _____ARE YOU PREGNANT? _____ARE YOU BREASTFEEDING? _____

SURGICAL HISTORY

PREVIOUS SURGIES (INCLUDE DATES IF POSSIBLE): _____

_____

HOSPITALIZATIONS _____