INSTRIDE/CAROLINA PODIATRY GROUP, INC – PATIENT INFORMATION

FIRST NAME _____ M.I. _____ LAST NAME _____

SSN# _____-_____-_____ DATE OF BIRTH _____/_____/_____

EMAIL: _____

MAILING ADDRESS: _____

_____ _____ _____
(CITY) (STATE) (ZIP CODE)

Primary phone number_____ is this home/cell/work?_____

Alternate number_____ is this home/cell/work?_____

MAY WE LEAVE A DETAILED MESSAGE AT THE ABOVE NUMBER(S)? Y or N

May we email you? Y or N

WHO MAY WE SPEAK WITH CONCERNING YOUR MEDICAL CARE?

_____

_____

How did you hear about our office? _____

Is there a POA handling your medical affairs Y or N If so, Who?_____

IF MINOR: LEGAL GUARDIAN: _____

FAMILY DOCTOR (PCP): _____ DATE LAST SEEN @PCP _____

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER: _____ GENDER: MALE FEMALE

RACE: WHITE BLACK/AFRICAN AMERICAN HISPANIC/LATINO OTHER: _____

EMERGENCY CONTACT: _____ Relationship:_____

PHONE: _____

MARITAL STATUS: M D S W

STUDENT STATUS: FULL-TIME PART-TIME NON-STUDENT

EMPLOYMENT STATUS: FULL-TIME PART-TIME UNEMPLOYED RETIRED

PLACE OF EMPLOYMENT: _____

Insurance: Name of insurance_____

(please provide card)

Policy Holder if other than self: _____ Policy holder date of birth_____

_____**date:**_____

Signature of patient or legal guardian attesting that all above information is true

Name: _____

INITIAL HEALTH HISTORY

What is the reason for your visit today? _____

ALLERGIES: FOOD - _____ INSECTS - _____
DRUG ALLERGIES - _____

WHAT MEDICATIONS ARE YOU TAKING?

_____ _____ _____

_____ _____ _____

May we send your prescriptions electronically? YES NO

PHARMACY NAME: _____ PHONE: _____

PHARMACY ADDRESS: _____

PAST MEDICAL HISTORY: CHECK ☑ CONDITIONS YOU **CURRENTLY** HAVE OR HAD IN THE PAST.

- ○ AIDS/HIV Positive
- ○ Alcoholism
- ○ Alzheimer's
- ○ Anemia
- ○ Anorexia
- ○ Appendicitis
- ○ Arthritis
- ○ Asthma
- ○ Back Problems
- ○ Bleeding Disorders
- ○ Cancer: type ____
- ○ Congestive Heart Failure
- ○ COPD
- ○ Drug Dependency
- ○ Diabetes
- ○ Emphysema
- ○ Epilepsy/Seizure
- ○ Fibromyalgia
- ○ Glaucoma
- ○ Gout
- ○ Heart Disease/Attack
- ○ Hepatitis: type ___
- ○ Hernia
- ○ Herpes
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Kidney Disease
- ○ Low Blood Pressure
- ○ Mononucleosis
- ○ Multiple Sclerosis
- ○ Pace Maker/Defib.
- ○ Pneumonia
- ○ Polio
- ○ Pregnancy
- ○ Prostate Problems
- ○ Stomach Ulcers
- ○ Stroke
- ○ Suicide Attempt
- ○ Thyroid Problems
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Urinary Tract Infection
- ○ Vascular Disease
- ○ Other: _____

PAST SURGERIES: PLEASE LIST ALL SURGERIES THAT YOU HAVE HAD (NOT JUST FOOT RELATED):

_____

_____

FAMILY HISTORY: DOES ANYONE IN YOUR **IMMEDIATE** FAMILY HAVE ANY MAJOR MEDICAL PROBLEMS? IF SO, LIST WHO AND WHAT: (please state if alive or deceased)

_____

SOCIAL HISTORY: DO YOU DRINK ALCOHOL? **Y** or **N** IF **YES,** HOW OFTEN? _____

DO YOU SMOKE OR USE TOBACCO? **Y** or **N** IF **YES,** # OF PACKS/DAY? _____ HOW LONG? _____YRS

IF YOU PREVIOUSLY SMOKED OR USED TOBACCO, HOW LONG SINCE YOU QUIT? _____

DO YOU OR HAVE YOU EVER USED ILLEGAL DRUGS? **Y** or **N** DID YOU GET A FLU SHOT THIS YEAR? **Y** or **N**

REVIEW OF SYSTEMS: CHECK ☑ SYMPTOMS YOU **CURRENTLY** HAVE OR HAD IN THE **RECENT** PAST.

CONSTITUTIONAL

- ○ CHILLS
- ○ FEVER
- ○ WEAKNESS
- FATIGUE
- ○ WEIGHT GAIN
- ○ DECLINE IN HEALTH

CARDIOVASCULAR

- ○ CHEST PAIN
- ○ HAIR LOSS ON LEGS
- ○ HISTORY OF HEART ATTACK
- ○ HEART MURMUR
- ○ CRAMPS IN LEGS/FEET
- ○ VARICOSE VEINS
- ○ HIGH BLOOD PRESSURE
- ○ PALPITATIONS
- ○ LEG OR FOOT ULCERS
- ○ SHORTNESS OF BREATH
- ○ LEGS/FEET DISCOLORED OR BLUISH

ENDOCRINE

- ○ INCREASED THIRST
- ○ INCREASED URINATION
- ○ COLD INTOLERANCE
- ○ THYROID TROUBLES

ENMT

- ○
- ○ DIFFICULTY HEARING
- ○ RINGING IN EARS
- ○ STUFFY/RUNNY NOSE
- ○ SORE THROAT

EYES

- ○ BLURRED VISION
- ○ CATARACTS
- ○ CONTACTS
- ○ DRY EYES
- ○ GLASSES
- ○ GLAUCOMA

GI

- BLOATING
- ○ BLOOD IN STOOL
- ○ BOWEL CHANGES
- ○ CONSTIPATION
- ○ DIARRHEA
- ○ HEARTBURN/ INDIGESTION
- ○ HEMORRHOIDS
- ○ NAUSEA
- ○ RECTAL BLEEDING
- ○ VOMITING

GU

- ○ PAINFUL URINATION
- ○ BLOOD IN URINE
- ○ BURNING IN URINATION
- ○ LACK OF BLADDER CONTROL
- ○ FREQUENT URINATION AT NIGHT
- ○ INCREASED URINATION

IMMUNOLOGIC

- ○ HIVES
- ○ SWELLING
- ○ RUNNY NOSE
- ○ SNEEZING
- ○ WATERY EYES
  ITCHY NOSE

LYMPHATIC

- ○ ANEMIA
- ○ BRUISE EASILY
- ○ SWOLLEN GLANDS
- ○ BLEED EASILY
- ○ BLOOD CLOTS

SKIN

- ○ BRUISE EASILY
- ○ DRYNESS
- ○ DRY, SCALY SKIN
- ○ NAIL TEXTURE CHANGE
- ○ SKIN COLOR CHANGE
- ○ HIVES
- ○ ITCHY SKIN
- ○ NON-HEALING WOUND
- ○ RASH
- ○ MOLE INCREASED SIZE

MUSCLE

- ○
- ○ ARTHRITIS
- ○ GOUT
- ○ MUSCLE CRAMPS
- ○ JOINT PAIN
- ○ BACK PROBLEMS
- ○ RESTRICTED MOTION

NEUROLOGICAL

- ○ NUMBNESS
- ○ PARALYSIS
- ○ STROKE
- ○ TINGLING
- ○ BURNING
- ○ UNSTEADY GAIT
- ○ BEHAVIORAL CHANGE

PSYCHIATRIC

- ○ DISTURBING THOUGHTS
- ○ MEMORY LOSS
- ○ PSYCHIATRIC DISORDERS
- ○ DEPRESSION
- ○ EXCESSIVE STRESS
- ○ DISORIENTATION
- ○ HALLUCINATIONS
- ○ NERVOUSNESS
- ○ SUICIDAL THOUGHTS
- ○ ANXIETY

RESPIRATORY

- ○ DIFFICULTY BREATHING
- ○ CHEST TIGHTNESS
- ○ COLD-LIKE SYMPTOMS
- ○ PERSISTENT COUGHING
- ○ COUGHING UP BLOOD
- ○ COUGHING UP PHLEGM
- ○ RECENT ASTHMA ATTACK
- ○ SLEEP APNEA
- ○ SHORTNESS OF BREATH
- ○ WHEEZING

By signing below, you state that the information provided above is accurate to the best of your knowledge. You also understand that this information is being gathered for the purpose of treating your foot condition as it may be caused by or affected by other underlying medical conditions. We may also use this information to assist emergency personnel in treating you if a medical emergency should arise.

Signature of Patient or Legal Guardian **Date**