VILLAGE DRIVE PODIATRY
PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ___ /___ /____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: __/__/___ AGE: ___ SEX: M☐ F☐
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?
HOME PHONE #: (___) ____-_____ YES☐ NO☐ CELL PHONE #: (___) ____-_____ YES☐ NO☐
WORK PHONE #: (___) ____-_____ YES☐ NO☐ E-MAIL: _____ YES☐ NO☐

PRIMARY LANGUAGE: _____
RACE:_____ ETHNICITY:_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ NO _____ YES NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?_____

YOUR MEDICAL HISTORY

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	NAME	DOSE
_____		_____	
_____		_____	

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
_____		_____	

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
ACID REFLUX	☐	☐	FIBROMYALGIA	☐	☐	NEUROPATHY	☐	☐
ANEMIA	☐	☐	GOUT	☐	☐	OPEN SORES/ULCERS	☐	☐
ARTHRITIS	☐	☐	HEART ATTACK	☐	☐	PNEUMONIA	☐	☐
ASTHMA	☐	☐	HEART DISEASE/FAILURE	☐	☐	POLIO	☐	☐
BACK TROUBLE	☐	☐	HEPATITIS	☐	☐	RHEUMATIC FEVER	☐	☐
BLADDER INFECTIONS	☐	☐	HIV+/AIDS	☐	☐	SICKLE CELL DISEASE	☐	☐
ABNORMAL BLEEDING	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SKIN DISORDER	☐	☐
BLOOD CLOTS	☐	☐	KIDNEY DISEASE	☐	☐	SLEEP APNEA	☐	☐
BLOOD TRANSFUSION	☐	☐	LIVER DISEASE	☐	☐	STOMACH ULCERS	☐	☐
BRONCHITIS/EMPHYSEMA	☐	☐	LOW BLOOD PRESSURE	☐	☐	STROKE	☐	☐
CANCER	☐	☐	MIGRAINE HEADACHES	☐	☐	THYROID DISEASE	☐	☐
DIABETES:TYPE 1 TYPE 2	☐	☐	MITRAL VALVE PROLAPSE	☐	☐	TUBERCULOSIS	☐	☐
OTHER CONDITIONS:								

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: _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ ☐ DAYS / ☐ WEEKS / ☐ MONTHS / ☐ YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED 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? _____

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? _____

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 RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

Patient Authorization

1. Consent to Treat: The Patient consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the.

2. Authorization to Release Information: I consent and authorize the release of my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care.

3. Financial Agreement: I hereby promise to pay for all products received or services rendered to me to the extent I am legally responsible for such payment. I understand that I am responsible for all over-the-counter convenience items and non-covered services and any other amounts that apply at the time of service or at the pre-operative appointment.

4. Privacy policy: I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I may request a copy of the Notice of Privacy Practices by calling my physician's office or requesting a copy in person. I acknowledge that I have read, understand and have been provided with the Notice of Privacy Practices.

_____ _____

SIGNATURE DATE