FAMILY FOOT CENTER
Stephen J. Chapman, D.P.M.
Summer R. Weary, D.P.M., Dr. Kimberly Wilkins, D.P.M.
120 Walnut Commons Lane, Suite A
Cookeville, TN 38501

2018 Updated Information Date: _____ Patient Number**:** _____

Patient Information:

Patient Name: Dr./Mr./Mrs./Ms.

_____
Last **First** **Middle**

SSN: _____-____-___Race:_____Marital Status:_____ Date of Birth: ____/____/___Age: _____

Address: _____ _____ _____

_____
City State Zip

Home#(___)____- _____ Cell#(___)_____-_____ Work# (___)_____-_____

Family Physician: Dr._____ Date of Last Visit:_____

Pharmacy Name and City: _____ **Emergency Contact:**_____

Insurance Information

Primary Insurance: _____ Secondary: _____

Insurance Subscriber Information(if different than patient)

Name: _____ SS#: _____ DOB: _____ Relationship: _____

(First) (M) (Last)

Although podiatry personnel primarily treat the area in and around your foot, your foot is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the podiatric care you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If Yes: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If Yes: _____
Have you ever experienced 2 falls OR any falls with injury in the last year ☐ Yes ☐ No If Yes: _____
Have you received an influenza vaccination this year? ☐ Yes ☐ No If Yes: _____
Have you received a pneumonia vaccination this year? ☐ Yes ☐ No If Yes: _____
Do You use tobacco? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No

Current Height: _____ Current Weight: _____ B/P: _____ Temp. _____

Pharmacy: _____

Medications/Dosage/Frequency:(Prescription and Non-Prescription)

_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____

Are you a diabetic? ☐ Yes ☐ No How long? _____ Do you use insulin? _____

What is your current problem?

_____

How long have you had this problem? _____Any treatment?

_____

Are you currently taking a blood thinner?_____ _____ _ __If so what amount?_____ ___

ALLERGIES?

Penicillin	Yes No	Anesthetics	Yes No	Ibuprofen	Yes No	Other_____
Sulfa	Yes No	Tapes	Yes No	Codeine	Yes No	
Aspirin	Yes No	Cortisone	Yes No	Lidocane	Yes No	

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize release of any medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge. I give my permission to the named provider(s)at Family Foot Center to perform and administer any necessary procedures.

_____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____

Staff Initial **Date**

2018 REVIEW OF SYSTEMS:

Constitutional (Please circle all that apply):

Chills
Depression
Easily Tired/Fatigue
Fever
Sleep Difficulty
Night Sweats
Weight Change

Cardiovascular (Please circle all that apply):

Chest Pain
Discoloration of toes/foot
Dizziness
Leg Cramps
Leg pain occurs at same distance
Shortness of breath when lying flat (Orthopnea)
Pain or fatigue in feet/legs with exercise/activity
Palpitations
Swelling in feet/legs (Edema)
Rapid Heart Beat (Tachycardia)
Varicose Veins

Respiratory (Please circle all that apply):

Shortness of Breath/Difficulty breathing
Cough (acute)
Cough (chronic)
Cough with blood-tinged sputum (Hemoptysis)
Emphysema
Exposure to TB
Wheezing

Gastrointestinal (Please circle all that apply):

Abdominal Pain
Acid Reflux
Bloating
Constipation
Diarrhea
Heartburn
Hemorrhoids
Nausea
Stomach Ulcer
Stool changes
Vomiting

Musculosketal (Please circle all that apply):

Ankle Instability (easy twisting injuries)
Back Pain
Difficulty/Pain with brisk walking/running
Flat Feet
Joint Pain
Leg Pain (shin splints)
Muscle Aches
Pain in feet getting out of bed
Swelling in joint
Swelling leg
"Toe-in" or "Toe-out" gait (walking)

Integumentary (Please circle all that apply):

Atypical moles
Dry skin
Pruritis (itching)
Rashes
Sores on foot or leg

Neurological (Please circle all that apply):

Burning in Feet
Easy to Fall
Headaches
Memory Loss
Numb Feet
Pain up the leg
Pain down the leg
Pain to Toes
Seizures
Tingling in Feet
Tremor
Vertigo/Dizziness
Weakness in Feet

Hematology (Please circle all that apply):

Easy Bruising
Excessive Bleeding
History of Blood Transfusion
Swollen lymph nodes

Endocrine (Please circle all that apply):

Difficulty Urination
Excessive Sweating
Frequent Urination
Hair Loss
Heat/Cold intolerance
Increased Hunger (Polyphagia)
Increased Thirst (Polydipsia)

Allergic/Immunologic (Please circle all that apply):

Difficulty Healing
Frequent Illness
Hepatitis
HIV Exposure
Hives (Uticaria)
Seasonal Allergies

☐ **None of the Above**

Patient

Name: _____

Date:

_____, 2018