# LoneStar Podiatry& Surgery, P.A.

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Social Security Number:________________________________________(MUST HAVE)

Last, First Name:______________________________ Date of Birth:____________ Age: ____________

Address:____________________________ City:________________ State:______ Zip:________

Home Phone:____________________ Cell:____________________ Work:____________

Marital Status: ☐ Single ☐Married ☐Widowed ☐Divorced ☐Separated Spouse Name:______________

Primary Care Physician:________________________ Date of last visit:____________________

Employer:______________________________ Occupation:__________________________

Who referred you to our office? ________________________________________

INSURANCE (MUST BE FILLED OUT)

Primary Insurance:________________________________ ID #: ____________________

Group #______________________________ ☐ Self ☐Spouse ☐Child

Primary Insured Social Security number:____________________ Date of Birth: ______________

Secondary Insurance:______________________________ ID #: ____________________

Group #______________________________ ☐ Self ☐Spouse ☐Child

Secondary  Insured Social Security number:____________________ Date of Birth: ______________

PHARMACY

Preferred Pharmacy Name:________________________ Address: ____________________

Phone: ____________________________ Fax: ______________________________

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AGREEMENT OF BENEFITS:

I hereby authorize physician permission to examine and treat my feet.  I also assign all medical and/or surgical benefits to include major benefits to which I am entitled, including Medicare, Private insurance and any other health plans to LoneStar Podiatry & Surgery, P.A.  I understand that I am responsible for scheduling with a participating physician and to follow up on any discrepancy in coverage with my insurance plan.  I understand that I am financially responsible for all charges allowable by my insurance, whether or not paid by my insurance.  I hereby authorize LoneStar Podiatry & Surgery, P.A. to release all information necessary to secure payment.

Signature:______________________________ Date:______________________

History

Height:________________________ Weight: ____________________ Shoe Size:______________

1. What is the main problem with your foot or ankle? ______________________________________________

________________________________________________________________________

________________________________________________________________________

2. Which foot or ankle has the condition? ☐ Right ☐ Left ☐ Both
3. Is this an injury? ☐ Yes ☐ No If yes, when did it occur?______________________
4. Did this happen at work? ☐Yes ☐ No Are you claiming workman's comp?________________
5. Check all of the following that apply:

Type of pain:

☐ Burning ☐Tingling ☐Sharp ☐Dull Ache ☐Shooting ☐Stabbing ☐ Numbness

When is it painful?

☐ While Standing ☐During Walking ☐After Walking ☐ During sports

☐Worse with activity ☐Better with Activity ☐ Worse when standing

☐ With Shoes ☐Without Shoes ☐ AM ☐PM ☐Lying in Bed ☐Always

6. How painful is your condition? "0" is no pain, "10" is the worst pain you have ever experienced. Please circle your pain.

0 1 2 3 4 5 6 7 8 9 10

7. How has this affected your daily routine and what activities does it keep you from?______________

________________________________________________________________________

________________________________________________________________________

8. Have you ever had foot care before? ☐ yes ☐ no If yes, when and by whom?___________________

MEDICATIONS

| MEDICATION | DOSAGE | HOW OFTEN TAKEN | WHAT IS IT FOR |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
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| | | | |
| | | | |

ALLERGIES

☐ NONE ☐ PENICILLIN ☐ SULFA ☐IODINE ☐ASPIRIN ☐ANESTHETICS ☐ LATEX

☐ FOOD ☐ CODEINE ☐DEMEROL ☐CORTISONE ☐ENVIRONMENTAL ☐ OTHER

If Other please describe: ____________________________________________________

Type of reaction: ______________________________

MEDICAL HISTORY

☐ Diabetes ☐ Fibromyalgia ☐ Tumors ☐ Nerve Conditions ☐ Heart Problems ☐ Arthritis
☐ Gout ☐ Asthma ☐ COPD ☐ Glaucoma ☐ Stomach Ulcers ☐ HIV/AIDS
☐ Skin disorder ☐ Tuberculosis ☐ Anemia ☐ Bursitis ☐ Lung Disease ☐ Stroke
☐ Reflux ☐ Kidney Disease ☐ Thyroid Disease ☐ Poor circulation ☐ High Blood Pressure
☐ High Cholesterol ☐ Colitis ☐ Osteoporosis ☐ Bleeding problems ☐ Joint implants
☐ Mental disorders: If yes, what kind? ______________ ☐ Hepatitis
☐ Other, Explain: ______________________________

Who is treating your diabetes? ______________________________

What is your average blood sugar reading? ______________________________

Are you pregnant? ☐ yes ☐ No If so, how many months? ______________________________

SURGICAL HISTORY

| SURGERY | DATE | COMPLICATION | INJURY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you been hospitalized for reasons other than surgery? ☐ Yes ☐ No Explain: ______________________________

______________________________

Have you ever had an injury to your lower extremity? ☐ Yes ☐ No Explain: ______________________________

______________________________

FAMILY HISTORY

| DISEASE | FATHER | MOTHER | SISTER | BROTHER |
|---|---|---|---|---|
| DIABETES | | | | |
| HEART DISEASE | | | | |
| HIGH BLOOD PRESSURE | | | | |
| ARTHRITIS | | | | |
| GOUT | | | | |
| THROID | | | | |
| CANCER | | | | |

SOCIAL HISTORY

Date of Last Physicial Exam: ______________________ Occupation: ______________________

Daily Activities, Personal & occupational: ______________________________

Do you drink alcohol? ☐ Yes ☐ No ☐ Socially

Do you use tobacco? ☐ Yes ☐ No If yes how much? ______________

REVIEW OF SYSTEMS

If you are experiencing any of the following, please check

EYES: ☐ Glasses ☐ Contacts ☐ Double vision ☐ Blurred vision ☐Cataracts ☐ Blindness

HEAD:☐ chronic headaches ☐concussion ☐Loss of consciousness

CV: ☐ Chest pain ☐shortness of breath ☐murmurs ☐anemia ☐ leg cramps

RESP: ☐Bronchitis ☐Pneumonia ☐wheezing ☐chronic cough

GI: ☐ Nausea ☐Vomiting ☐Diarrhea ☐ Constipation ☐Weight Gain/loss ☐ blood in stool ☐loss of appetite

G/U: ☐ chronic kidney/bladder infections ☐ frequency of urination ☐discharge from penis/vagina

SKIN: ☐ dry ☐flakey ☐ ulcers ALLERGY: ☐ allergic reaction GYN: ☐ Irregular/painful period ☐absence of period

Do your legs swell? ☐ yes ☐ no

Do you have back problems or have had a back injury? ☐ yes ☐ no

_____________ I am not experiencing any of the above symptoms.

NOTICE OF PRIVACY PRACTICE (HIPPA)

Posted in our office and available to you upon request is a document entitled "Notice of Privacy Practices." It is required by governmental regulation that all medical facilities provide you with access to this notice. Please sign below indicating that you have read this notice or are declining the offer to read this notice but are aware of the privacy policies.

Signature: ______________________________________ Date: ______________________________________