FAMILY FOOT AND ANKLE CENTER OF MAINE

205 French St, Bangor, ME 04401

PATIENT INFORMATION

Today's Date ____/____/_______

Last Name________________________ First Name__________________ Middle___

Birth Date ___/___/_______ Sex M F Social Security #_____-_____-_____

Address __________________________________ Home Phone_________________

City/State __________________________Zip_______ Cell Phone________________

Employer_________________________________ Work Phone __________________

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Emergency Contact __________________________ Phone _____________________

E Mail __________________________OK to contact me by Phone or E mail? Y__N_

Insurance Information

Insurance Company Name____

Secondary Insurance Company____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other________________

Physician Information

Primary Care Physician_______________________ City/State____________________

Referred by ________________________ Previous Podiatrist_____________________

Pharmacy Preference_____________________________ Location________________

Demographics (government requirement)

Race ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander

Primary Language ☐ English ☐ French ☐ Spanish ☐ Other__________________

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Current Foot/Ankle Problem ____

____

How long have you had this problem? _______________ Was there an injury?_____

Which side? ☐ Left ☐ Right ☐ Both Have you had prior treatment? ___________

Shoe size_________Height___________Weight________Blood pressure_____/_____

Social History

Do you smoke? ☐ No ☐ Yes How Much? ___________How Long?_____________

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ______________________

List physical activities you participate in_____________________________________

Family history

Has anyone in your immediate family ever had? **Please check all that apply**

☐ Diabetes	☐ Bleeding	☐ Foot problems
☐ Heart disease	☐ Hypertension	☐ Skin disorders
☐ Cancer	☐ Blood clots	☐ Others (list)
☐ Stroke	☐ Kidney	
☐ Arthritis	☐ Liver	____________________

Past Medical History (please check all that apply)

Cardiovascular

- ☐ Blood clot/phlebitis 451.19
- ☐ A–fibrillation 427.31
- ☐ Heart attack 414.00
- ☐ Chest pain (angina) 306.2
- ☐ High blood pressure 401.1
- ☐ High cholesterol 272.6
- ☐ Poor circulation (PVD) 440.20
- ☐ Stroke 432.9
- ☐ Varicose veins 454.9

Musculoskeletal

- ☐ Osteoarthritis 715.00
- ☐ Rheumatoid arthritis 714.0
- ☐ Fibromyalgia 729.0
- ☐ Gout 274.01
- ☐ Back problems 724.2

Respiratory

- ☐ Asthma 493.10
- ☐ COPD 496
- ☐ Sleep apnea 780.57

Neurological

- ☐ Seizure disorder 345.10
- ☐ Stroke 432.9
- ☐ Mini stroke (TIA) 432.9
- ☐ Peripheral neuropathy 337.09

Other (list)

Gastrointestinal

- ☐ Acid reflux (GERD) 530.81
- ☐ Ulcers 531.70
- ☐ Hepatitis 571.40

Skin

- ☐ Psoriasis 696.1
- ☐ Skin cancer 173.9
- ☐ Ulcerations 707.10
- ☐ Athlete's foot 110.4
- ☐ Dry skin 705.0

Endocrine

- ☐ Diabetes 250.00
- ☐ Hypothyroidism 243
- ☐ Hyperthyroidism 242.00

Urinary

- ☐ Kidney failure 586
- ☐ Dialysis 586

Other

- ☐ Cancer 239.9
- ☐ Anemia 280.9
- ☐ HIV/AIDS 042
- ☐ Anxiety/depression 300.00
- ☐ Mental illness 300.90
- ☐ Lupus/Sjogren's 710.00

Please list any surgical procedures that you have undergone

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Review of systems

- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue
- ☐ Fever/chills
- ☐ Blurred vision
- ☐ Double vision
- ☐ Swelling of feet
- ☐ Incontinence
- ☐ Balance problems
- ☐ Headaches
- ☐ Weakness
- ☐ Nausea/vomiting
- ☐ Joint stiffness
- ☐ Constipation
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Trouble walking
- ☐ Cold feet
- ☐ Muscle cramps
- ☐ Tremors
- ☐ Memory loss
- ☐ Dizziness
- ☐ Fainting
- ☐ Night sweats
- ☐ Rash
- ☐ Masses
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Slow healing
- ☐ Chest pain
- ☐ Ear ringing
- ☐ Dry eyes
- ☐ Sprains
- ☐ Broken bones
- ☐ Other_____________

____

List Current Medications (include over-the-counter, herbal and vitamins)

1__________________________________ 2______________________________

3__________________________________ 4______________________________

5__________________________________ 6______________________________

7__________________________________ 8______________________________

9__________________________________ 10_____________________________

Allergies:

☐ Penicillin
☐ Tape
☐ Aspirin
☐ NSAIDs
☐ Local anesthetic
☐ Codeine
☐ Iodine
☐ Shellfish
☐ Latex
☐ Other
____

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you as well as the release of my medical information to them.

I authorize and assign to Family Foot and Ankle Center of Maine, all insurance benefits, if any, otherwise payable to me for services rendered and understand that I accept financial responsibility for all charges whether or not paid by insurance. I authorize the provision of information concerning my healthcare to my insurance company.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the notice. I authorize the release of my medication information between my pharmacy(s) and the doctors.

Patient or authorized person's signature:

____Date___________________________