NAME: _____

TODAY'S DATE: _____

DATE OF BIRTH: _____ GENDER: -M -F

WEIGHT: _____ HEIGHT: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

CIGARETTE/TOBACCO USE (CIRCLE ONE): NEVER FORMER CURRENT

FORMER & CURRENT SMOKERS, LIST # YEARS SMOKED & PACKS/DAY: #_____&_____/day

ALCOHOL USE: NEVER SOCIALLY HEAVILY HISTORY OF ALCOHOLISM

RECREATIONAL DRUG USE: NO YES

PATIENT ADDRESS **EMERGENCY CONTACT**

ADDRESS: _____ NAME: _____

CITY, STATE, ZIP: _____ RELATIONSHIP: _____

PHONE: _____ CELL:_____ PHONE:_____

ADDITIONAL INFORMATION **EMPLOYER INFORMATION**

PHARMACY: _____ EMPLOYER: _____

LOCATION: _____ ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EMAIL ADDRESS: _____ REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY: _____ SECONDARY:_____

ARE YOU THE PRIMARY CARDHOLDER? Y N ARE YOU THE PRIMARY CARDHOLDER? Y N

NAME OF PRIMARY CARDHOLDER:_____ NAME OF PRIMARY CARDHOLDER:_____

DATE OF BIRTH: _____ RELATIONSHIP:_____ DATE OF BIRTH:_____ RELATIONSHIP:_____

FAMILY HISTORY	FATHER	MOTHER	BROTHER	SISTER	NONE
HIGH BLOOD PRESSURE	( )	( )	( )	( )	( )
HEART DISEASE	( )	( )	( )	( )	( )
DIABETES	( )	( )	( )	( )	( )
ARTHRITIS	( )	( )	( )	( )	( )
ALCOHOLISM	( )	( )	( )	( )	( )
GOUT	( )	( )	( )	( )	( )

PRIOR SURGERIES

PROCEDURE	YEAR	NAME OF DOCTOR
1.		
2.		
3.		

NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH FEDERAL GOVERNMENT PRIVACY RULES IMPLEMENTED THROUGH THE HEALTHCARE PORTABILITY ACT OF 1996 (HIPAA) IN ORDER FOR YOUR PHYSICIAN OR STAFF OF DR. HARVEY TO DISCUSS YOUR CONDITION WITH MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS THAT YOU DESIGNATE, WE MUST OBTAIN YOUR AUTHORIZATION PRIOR TO DOING SO. SHOULD YOU LIKE A COPY OF THE PRIVACY PRACTICE, YOU MAY REQUEST A COPY.

DO WE HAVE PERMISSION TO:

LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? Y N

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? Y N

DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD?

IF YES, WHOM_____ RELATIONSHIP: _____

TREATMENT CONSENT

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FEET.

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____

RELATIONSHIP TO PATIENT **DATE**

NAME: _____ **TODAY'S DATE:**_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

(PLEASE CIRCLE)

ARTHRITIS	Y N	HIV+/ AIDS	Y N
ABNORMAL BLEEDING	Y N	HIGH BLOOD PRESSURE	Y N
BLOOD CLOTS	Y N	KIDNEY DISEASE	Y N
BLOOD TRANSFUSION	Y N	LIVER DISEASE	Y N
CANCER	Y N	LOW BLOOD PRESSURE	Y N
DIABETES	Y N	MIGRAINE HEADACHES	Y N
FIBROMYALGIA	Y N	NEUROPATHY	Y N
GOUT	Y N	OPEN SORES	Y N
HEART ATTACK	Y N	SKIN DISORDER	Y N
HEART DISEASE/FAILURE	Y N	STOMACH ULCERS	Y N
HEPATITIS	Y N	STROKE	Y N

MEDICATIONS & ALLERGIES

( ) I DO NOT TAKE ANY MEDICATIONS

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION NAME	MEDICATION STRENGTH
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE CHECK ONE:

( ) I DO NOT HAVE ANY KNOWN MEDICATION ALLERGIES

( ) MY KNOWN MEDICATION ALLERGIES ARE:_____

ARE YOU A DIABETIC?

( ) YES ( ) NO

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?_____

_____

PLEASE CHECK WHICH FOOT AND/OR TOES ARE BOTHERING YOU

( ) BOTH FEET **( ) RIGHT FOOT** **( ) LEFT FOOT**

( ) TOES (PLEASE CIRCLE) **1 2 3 4 5** **1 2 3 4 5**

HOW LONG AGO DID THIS PROBLEM FIRST START?_____

DID YOUR PAIN OR PROBLEM:

( ) BEGIN ALL OF A SUDDEN **( ) GRADUALLY DEVELOP OVER TIME**

HOW WOULD YOU DESCRIBE YOUR PAIN?

( ) NO PAIN **( ) SHARP** **( ) DULL**

( ) ACHING **( ) BURNING** **( ) ITCHING**

( ) RADIATING **( ) STABBING** **( ) OTHER**

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 1 TO 10? (CIRCLE ONE)

(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?

( ) WALKING **( ) STANDING** **( ) DRESS SHOES**

( ) RESTING **( ) RUNNING** **( ) HIGH HEELS**

( ) DAILY ACTIVITIES **( ) FLAT SHOES** **( ) CLOSED TOE SHOE**

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? Y N