Let's Get Acquainted

Please complete the following as fully as possible,
as this information will help us to help you.

Patient's name: ____
Address: ____
City: ________________________ State: ________ Zip code: ________
Phone #: _____________________ Date of birth: __________________
Cell Phone#: __________________ (To be used only if we can't reach you)
E-Mail address: _________________________________
Marital status: ☐S ☐M ☐W ☐D Gender: ☐M ☐F
Social Security #: _______________
Guardian if patient is a minor: ___________________________________
Guardian's address if different from above: __________________________
Employer: ____
Occupation: _____________________ Work phone #: _______________
Business address: ____
Primary care physician: __________________ Phone #: ______________
Date of last visit to your primary care physician: _______________

Insurance information

Primary insurance: _______________ Secondary insurance: _____________
Policy holders date of birth: __________ Social security #: ______________
Spouse's insurance: _________________ Spouse's date of birth: __________
Spouse's or parent's employer: __________________________________
Do you have prescription coverage (a drug plan)? ☐Yes ☐No ☐Unsure
Name of Pharmacy _________________ Street and City _________________

New patients are referred by other enthusiastic patients,
and we would like to thank them…

Referred by: _______________________________________

Is there someone we can call if we cannot reach you regarding an appointment?
Name: ___________________________ Phone #: ___________________

Please complete the medical history section on the next page.

PATIENT MEDICAL HISTORY

Patient Name___________________________________ Date ____________

- Please describe the foot problem that brought you to the office today:
  ____
  ____
- Do you have or have ever had any of the following?

- ☐ Abnormal blood pressure
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma / Emphysema
- ☐ Bleeding disorders /Blood clots
- ☐ Cancer
- ☐ Current pregnancy
- ☐ Diabetes
- ☐ Difficulty healing
- ☐ Gout
- ☐ Heart condition
- ☐ H.I.V. positive / AIDS
- ☐ Kidney disease
- ☐ Liver disease/Hepatitis
- ☐ Muscular disorders / diseases
- ☐ Neurological disorders / diseases
- ☐ Seizures / Epilepsy
- ☐ Sexually transmitted disease
- ☐ Stomach ulcers / GERD / IBS
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis

- Please describe any other medical problems you have that are not mentioned above____
- Please describe any surgeries or hospitalizations within the last five years
  ____
- Are you currently taking any medication regularly? Please list prescription and non-prescription products ____
  ____
- I am allergic to or can not take:

- ☐ Penicillin
- ☐ Cortisone
- ☐ Codeine
- ☐ Shellfish
- ☐ Iodine
- ☐ Antibiotics
- ☐ Sulfa
- ☐ Aspirin
- ☐ Local anesthesia
- ☐ Tape
- ☐ Latex
- ____________

- Do you have any family history of Diabetes, Cancer, Heart disease, Blood clots, Bleeding problems, Strokes, Gout? If yes, which family member ________________
- Smoking Status: ☐Current every day, ☐Current some days, ☐Former, ☐Never
- Do you drink alcohol? ☐Yes ☐No If yes, how much? _________________
- Do you drink caffeinated beverages? ☐Yes ☐No If yes, how much? ___________
- Does your work or lifestyle involve spending large amounts of time on your feet? ☐Yes ☐No If yes, please describe _______________________________________
- Do you exercise? ☐Yes ☐No If yes, how often and how much ________________
- Height: ________ Weight: ________ Shoe size: ___________

PATIENT NAME:_________________________ **DATE:** ___________

DEAR PATIENT: PLEASE CHECK ANY PROBLEMS YOU CURRENTLY ARE EXPERIENCING OR HAVE EXPERIENCED IN THE PAST.

CONSTITUTIONAL

☐decreased appetite ☐faintness ☐dizziness ☐headache ☐fever
☐difficulty breathing when lying flat ☐feeling room spinning ☐weakness
☐weight loss ☐weight gain

CARDIOVASCULAR

☐chest or arm pain ☐ blood clots ☐cramps in legs or feet when walking
☐cramps in legs or feet when sleeping ☐high blood pressure
☐low blood pressure ☐ heart attack ☐heart murmur ☐heart palpitations
☐stroke ☐varicose veins ☐mitral valve prolapse

MUSCULOSKELETAL

☐joint ache or pain ☐chronic neck pain ☐chronic hip pain
☐chronic low back pain ☐chronic ankle pain ☐stiffness ☐morning stiffness
☐weakness ☐foot pain ☐pain in feet in the morning ☐pain upon rising anytime
☐swelling of joints ☐limited motion in joints

INTEGUMENT

☐allergy to chemicals ☐scarring ☐dry skin ☐itching skin ☐cracking skin
☐thick or discolored toenails ☐thick or discolored finger nails ☐skin rash
☐scaring after surgery or injury ☐skin cancer ☐pain associated with skin

NEUROLOGICAL

☐tingling ☐pins and needles ☐numbness ☐increased sensitivity to touch
☐burning ☐decreased or lack of sensation to touch ☐shooting pain
☐decreased or lack of sensation to heat or cold ☐radiating pain

ENDOCRINE

☐increase or decrease in thirst ☐increase or decrease in appetite
☐increase or decrease in urination ☐weight loss or gain ☐diabetes mellitus
☐thyroid problems ☐post-menopause

HEMATOLOGICAL/LYMPHATIC

☐hemophilia ☐anemia ☐bruise easily ☐blood transfusion reaction
☐leukemia ☐sickle cell disease or trait ☐weakness
☐yellow discoloration of the skin

Patient Signature ____

Doctor Reviewed, signed & dated___________________________________

MICHIGAN PODIATRY INSTITUTE, P.C.

Peripheral Arterial Disease – Peripheral Vascular Disease

PAD – PVD SELF TEST

Patient Name: ______________________________ Date: _______________

Please check the correct answer

Do you have a heart condition or have you had a previous heart attack?	☐**YES**	☐ **NO**
Do you have high blood pressure or have you ever had a stroke?	☐**YES**	☐ **NO**
Do you have diabetes?	☐**YES**	☐ **NO**
Do you have a family history of diabetes, heart problems or poor circulation?	☐**YES**	☐ **NO**
Do you have any aching or cramping in your legs when you walk or exercise?	☐**YES**	☐ **NO**
If so, does this pain go away when you stop and rest?	☐**YES**	☐ **NO**
Do you believe that you have poor circulation?	☐**YES**	☐ **NO**
Do you have pain in your feet or toes at night?	☐**YES**	☐ **NO**
If so, does this pain disturb your sleep?	☐**YES**	☐ **NO**
Do you have any ulcers or sores on your feet that are hard to heal?	☐**YES**	☐ **NO**
Do you smoke?	☐**YES**	☐ **NO**
Have you ever smoked?	☐**YES**	☐ **NO**
Are you more than 25 pounds overweight?	☐**YES**	☐ **NO**
Do you eat fried or fatty foods more than three times a week?	☐**YES**	☐ **NO**
Do you have an inactive lifestyle?	☐**YES**	☐ **NO**
Has your lifestyle changed due to leg pain?	☐**YES**	☐ **NO**

The more “YES” answers you have circled – the more important it is for you to Get checked for PAD or PVD

MICHIGAN PODIATRY INSTITUTE, P.C.

☐ I hereby give my permission to Dr. Alan Cornfield or Dr. Randy Kaplan to administer treatment and to perform such minor operative procedures as may be necessary in the diagnosis and/or treatment of my foot and/or ankle condition.

☐ MEDICARE –
I request payment of authorized Medicare benefits be made, on my behalf, to Michigan Podiatry Institute, P.C. for any services furnished to me by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and it's agents any information needed to determine those benefits or the benefits payable for related services.

☐ INSURANCE COMPANIES –
I authorize release of my personal health information to my insurance companies. I authorize Michigan Podiatry Institute, P.C. to act as my agent in helping me to obtain payment, from my insurance companies, for services rendered. I authorize payment directly to Michigan Podiatry Institute, P.C. I understand that I am ultimately responsible for my bill if it is not paid by my insurance company.

☐ NOTICE OF PRIVACY PRACTICES –
I acknowledge that I was provided a copy of the Notice of Privacy Practices of Michigan Podiatry Institute, P.C. I understand that if I have any questions regarding the Privacy Practices they will be addressed by the Privacy Officer.

____________________________________ ____________
Patient's Name Date

____
Patient's Authorized Representative

____
Signature