



HARLIS FAMILY FOOT AND ANKLE

WHERE YOUR FOOT CARE IS A FAMILY MATTER

DATE: ___/___/___

PATIENT NAME: _____

DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

HOME PHONE #: (____) ____ - _____

WORK PHONE #: (____) ____ - _____

CELL PHONE #: (____) ____ - _____

E-MAIL: _____

SOCIAL SECURITY #: _____

MARITAL STATUS: _____

PRIMARY LANGUAGE: _____

RACE: _____

ETHNICITY: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____

PHONE #: (____) ____ - _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE #: (____) ____ - _____

PRIMARY CARE DOCTOR: _____

Patient Name:

Date of Birth:



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PHONE: _____

PHARMACY: _____ ADDRESS: _____

PHONE #:(_____)_____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION WITH? YES NO

IF YES,
NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____

RELATIONSHIP TO PATIENT? _____ ADDRESS: _____

CITY/STATE: _____ ZIP: _____ PHONE #:(_____)_____-_____

HOW DID YOU HEAR ABOUT THE PRACTICE(circle one)

INTERNET/GOOGLE ___ FRIEND/FAMILY ___ DOCTOR REFERRAL (who?) _____

INSURANCE COMPANY ___ FACEBOOK ___ OTHER _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY NAME:

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE #:(_____)_____-_____ INSURED NAME: _____

DATE OF BIRTH _____ EMPLOYER _____

CONTRACT# _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME:

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

Patient Name:

Date of Birth:



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PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY

DATE

SOCIAL HISTORY (PLEASE CIRCLE)

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED
DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE

CURRENT USE: RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT CURRENTLY SMOKING

SMOKE ____ PACKS/DAY FOR ____ YEARS

IF NO LONGER SMOKING, HOW LONG AGO DID YOU QUIT? _____

USE OF RECREATIONAL DRUGS: NEVER QUIT HOW LONG AGO? _____

TYPE _____

CURRENT USE : TYPE _____ RARE OCCASIONAL MODERATE
DAILY

EMPLOYER: _____

OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? YES NO

Patient Name:

Date of Birth:



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CHILDREN – AGE(S) _____

ELDERLY OR DISABLED FAMILY MEMBER OTHER

PET(S) – WHAT KIND? _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY
SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE:

FAMILY HISTORY (PLEASE CIRCLE)

DO YOU HAVE A FAMILY HISTORY OF: DIABETES: TYPE 1 OR TYPE 2

CANCER HEART DISEASE HIGH BLOOD PRESSURE STROKE

CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS

OTHER (LIST BELOW)

YOUR MEDICAL HISTORY

ALLERGIES: (PLEASE CIRCLE)

MEDICATIONS TAPE IODINE SHELLFISH ANESTHESIA LATEX
FOODS

IF ANY ABOVE CIRCLED, PLEASE LIST BELOW ALONG WITH YOUR REACTION

Patient Name:

Date of Birth:



HAVE YOU EVER HAD ANY OF THE FOLLOWING?
 (PLACE X NEXT TO THOSE THAT APPLY)

ACID REFLUX	FIBROMYALGIA	NEUROPATHY	ANEMIA
GOUT	OPEN SORES	ARTHRITIS	HEART ATTACK
PENUMONIA	ASTHMA	HEART DISEASE	HEART FAILURE
POLIO	BACK TROUBLE	HEPATITIS	RHEUMATIC FEVER
BLADDER INFECTIONS	HIV/AIDS	SICKLE CELL DISEASE	HIGH BLOOD PRESSURE
ABNORMAL BLEEDING	SKIN DISORDER	BLOOD CLOTS	KIDNEY DISEASE
SLEEP APNEA	BLOOD TRANSFUSION	LIVER DISEASE	STOMACH ULCERS
BRONCHITIS	EMPHYSEMA	LOW BLOOD PRESSURE	STROKE
CANCER	MIGRAINE/HEADACHES	THYROID DISEASE	DIABETES TYPE 1
DIABETES TYPE 2	MITRAL VALVE PROLAPSE	SPINAL STENOSIS	COPD

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM(S) BRINGS YOU TO OUR OFFICE TODAY?

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM (CIRCLE ONE):

BEGIN ALL OF A SUDDEN OR GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN (CIRCLE ONE)? NO PAIN SHARP DULL
 ACHING BURNING RADIATING ITCHING STABBING OTHER

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

Patient Name:

Date of Birth:



(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(CIRCLE ONE):

STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?

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?

WAS THIS PROBLEM CAUSED BY AN INJURY (CIRCLE ONE)? NO YES
(DESCRIBE)_____

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT

PARENT OR GUARDIAN IF OTHER THAN PATIENT

RELATIONSHIP TO PATIENT

Patient Name:

Date of Birth: