

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_



## Patient History Form

*(Please fill out completely)*

### PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M / F Shoe Size: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**EMail:** \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Address: \_\_\_\_\_

How did you hear about us?  Internet Search  Website  Magazine  
 Physical Therapist: \_\_\_\_\_  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Primary

Secondary

Subscriber Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

I.D. Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Patients Relationship to policy holder:  Self  Spouse  Child  Other

**Check here if you believe Worker's Compensation is responsible for payment.**

### RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize ARIZONA ORTHOPAEDIC FOOT & ANKLE CENTER, LLC to release information regarding treatment or examination rendered to me for medical or surgical care to insurance company(s) or it's representatives. I also authorize payment to be made directly to ARIZONA ORTHOPAEDIC FOOT & ANKLE CENTER, LLC in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company. Furthermore, I authorize ARIZONA ORTHOPAEDIC FOOT & ANKLE CENTER, LLC to obtain my medical records from any necessary hospital, clinic, or doctor's office.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

\_\_\_\_\_  
Practitioner's Initials / Date

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### HISTORY OF PROBLEM

Foot: R L       Ankle: R L

Did the problem result from a specific injury?  Yes  No    **Injury/Accident Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Did your problems begin following:  Work Injury?     Motor Vehicle Accident?

Other: \_\_\_\_\_

Describe how you got injured?

\_\_\_\_\_  
\_\_\_\_\_

If neither, how long have you had the condition? \_\_\_\_\_

Please rate your pain on a scale from 1 to 10 (*10 being the most painful*):

**At Rest:** 1 2 3 4 5 6 7 8 9 10                      **At its worst:** 1 2 3 4 5 6 7 8 9 10

Is the pain:  **Constant**     **Occasional**     **Sharp**     **Dull**     **Aching**     **Stabbing**     **Throbbing**

What symptoms are you experiencing?  **Locking**     **Catching**     **Giving Way**     **Popping**     **Grinding**

**Other** \_\_\_\_\_

What, if anything, makes your symptoms **better**? \_\_\_\_\_

What, if anything, makes your symptoms **worse**? \_\_\_\_\_

Have you seen another physician for this injury?     **Yes**     **No**

If yes, who? \_\_\_\_\_ Phone # \_\_\_\_\_

What treatments have you tried?  **Nothing**     **Physical Therapy**     **Chiropractic**     **Bracing**

**Orthotics**     **Injections** (for example: Cortisone)     **Medications** \_\_\_\_\_

**Other** \_\_\_\_\_

Have you had any of the following tests/studies?

<i>Test</i>	<i>Date (month / year)</i>	<i>What facility? (clinic / hospital)</i>
<input type="checkbox"/> <b>X-rays</b>	_____	_____
<input type="checkbox"/> <b>MRI scan</b>	_____	_____
<input type="checkbox"/> <b>CT scan</b>	_____	_____
<input type="checkbox"/> <b>EMG/NCV</b>	_____	_____

\_\_\_\_\_ Practitioner's Initials / Date

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure             | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Kidney Disease/Problem |
| <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Heart Disease or Attack         | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Thyroid                |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> High Lipids (cholesterol, etc.) | <input type="checkbox"/> Psoriasis              |
| <input type="checkbox"/> Ulcer Disease                   | <input type="checkbox"/> Polio                  |
| <input type="checkbox"/> Gastritis                       | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Reflux Disease (GERD)           | <input type="checkbox"/> Gout                   |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Depression             |

Others, please list: \_\_\_\_\_

Have you ever had a blood clot/DVT?  Yes  No If yes, when? \_\_\_\_\_

Treatment:  Medication (blood thinner)  IVC filter  Other: \_\_\_\_\_

### SOCIAL HISTORY

Marital Status:  Married  Single  Divorced  Widowed  Living with Other  Living Alone

Tobacco Use:  Yes  No Type: \_\_\_\_\_ Duration: \_\_\_\_\_ Quit Date: \_\_\_\_\_

Alcohol Use:  Yes  No Frequency: \_\_\_\_\_

Recreational Drug Use:  Yes  No Type & Frequency: \_\_\_\_\_

### PAST SURGICAL HISTORY

Please list all surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_ Practitioner's Initials / Date



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**REVIEW OF SYSTEMS** (please check all that apply)

- |                           |  |                    |   |
|---------------------------|--|--------------------|---|
| 1) CONSTITUTIONAL         | <input type="checkbox"/> None<br><input type="checkbox"/> Weight changes<br><input type="checkbox"/> Chills<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Weakness/Fatigue                 | 7) MUSCULOSKELETAL | <input type="checkbox"/> None<br><input type="checkbox"/> Arthritis/joint stiffness<br><input type="checkbox"/> Muscle aches<br><input type="checkbox"/> Swelling of joints                             |
| 2) EYES                   | <input type="checkbox"/> None<br><input type="checkbox"/> Vision change<br><input type="checkbox"/> Glasses/Contacts<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Glaucoma            | 8) SKIN            | <input type="checkbox"/> None<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Ulcers   |
| 3) EARS, NOSE &<br>THROAT | <input type="checkbox"/> None<br><input type="checkbox"/> Hearing loss<br><input type="checkbox"/> Ear ache or infection<br><input type="checkbox"/> Ringing<br><input type="checkbox"/> Hoarseness        | 9) NEUROLOGICAL    | <input type="checkbox"/> None<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Fainting/blackouts<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Numbness, tingling |
| 4) CARDIOVASCULAR         | <input type="checkbox"/> None<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Swelling in legs<br><input type="checkbox"/> Shortness of breath<br><input type="checkbox"/> Palpitations | 10) PSYCHIATRIC    | <input type="checkbox"/> None<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Mood swing                 |
| 5) RESPIRATORY            | <input type="checkbox"/> None<br><input type="checkbox"/> Shortness of breath<br><input type="checkbox"/> Wheezing/Asthma<br><input type="checkbox"/> Frequent Cough                                       | 11) ENDOCRINE      | <input type="checkbox"/> None<br><input type="checkbox"/> Excessive thirst or hunger<br><input type="checkbox"/> Hot/cold intolerance<br><input type="checkbox"/> Hot flashes                           |
| 6) GASTROINTESTINAL       | <input type="checkbox"/> None<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Acid Reflex<br><input type="checkbox"/> Nausea or vomiting<br><input type="checkbox"/> Abdominal Pain      | 12) HEMATOLOGICAL  | <input type="checkbox"/> None<br><input type="checkbox"/> Easy bruising<br><input type="checkbox"/> Easy bleeding<br><input type="checkbox"/> Anemia  |

DUE TO THE NATURE OF OUR SPECIALIZED PRACTICE, EXTENDED WAITING PERIODS MAY OCCUR. WE APOLOGIZE IN ADVANCE FOR ANY INCONVENIENCE. WE ARE TRYING TO PROVIDE THE BEST MEDICAL CARE FOR EACH INDIVIDUAL PATIENT.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Print name: \_\_\_\_\_

\_\_\_\_\_ Practitioner's Initials / Date