WELCOME TO OUR OFFICE!

NEW PATIENT INTAKE FORM

Name:____Gender _____M _____F

Date of Birth:________________________Age_________________Social Security #:______________________

Address: ________________________________City:___________________________State:____Zip________

Home Phone #:__________________Work Phone#:_________________Cell Phone:_______________________

E-Mail Address:______________________________ Emergency Contact: _________________Phone:_________

Primary Physician: ________________________ Referred by: _______________________________

Pharmacy :______________________________ Address:___________________________________

*****Please describe your foot/ankle problem (include date of injury if applicable) *****

How long has the problem been present? ____

Have you had any treatment or seen someone for it? ____

Have you had any prior foot/ankle problems? If yes, please describe: ___No Yes_________________________

____

ALLERGIES

Please check all allergies:

_____Medications:____

____Foods:____

_____Tapes or Topical Skin Sensitivity____Other/Reactions:____

MEDICATIONS

Please list all medications and the dosages: Our electronic records usually sync with your pharmacy, but if you have a copy of your medications please hand it to staff to copy.

____

____

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

__Check those that apply to you**__**

	Frequent Headache/Migraines		Anemia/Blood Disorders
	Liver Disorder		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy or Seizures
	Diabetes Average Blood Sugar ______		Prolonged Bleeding Time
	Asthma		Stomach/Ulcer Disorder
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems/Tension
	BLOOD CLOTS		Asthma/Hay Fever/Shortness of Breath
	Tumor/Abnormal Growth/Cancer		Sexually Transmitted Disease
	Ear, Nose, Throat Disorder		Prostate Disorder
	Hepatitis/HIV		Other

Are there any significant diseases or conditions that exist in your immediate family? ___________________________________

____

Do you smoke currently?_______Yes _____No
Have you smoked previously?______Yes___No
Number of caffeine drinks per day? ________ Amount of alcohol consumed per week ______
For women only: Are you pregnant? ________ How many months? ______

Height: __________**Weight:** ________**Shoe size:** ________Occupation: ____

MEDICAL CONDITIONS:

****Please circle off all that *currently* apply to you****

Muscular/ Skeletal: ___ back pain ___ joint pain ___ joint redness ___ joint swelling ___ leg cramps ___ morning stiffness
___ muscle tenderness ___ neck pain ___ stiffness ___ weakness of muscles ___ difficulty with walking

Neurological: ___ burning in feet tingling in feet or toes ___ numbness ___ tremors
Psychiatric: ___ addictions ___ attempted suicide ___ depression ___ memory loss ___ panic attacks

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due at time of service.

I give **Mid Penn Foot & Ankle Specialists** permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to **Mid Penn Foot & Ankle Specialists** office policy.

___________________________ ____

DATE **SIGNATURE OF PATIENT OR LEGAL GUARDIAN**

**If not patient, relationship to patient:
Parent ______Power of attorney ___Legal Guardian ___Other: _______________