Armada Foot and Ankle Clinic

WELCOME TO OUR CLINIC

(Please Print)

Date: _____ Home Phone # (_____) _____ Cell Phone#(____)_____ E-mail_____

PATIENT INFORMATION

Name: _____ DOB: _____ Gender: ☐ F ☐ M Social Security #: _____

Address:_____
(street, city, state, zip code) (also post office box, please)

Guardian's Name (If patient is a minor):_____ Address_____
(If different from the patient's)

Employer/School: _____ Occupation: _____ Work Phone#: (_____) _____

Employer/School Requires you to: ☐Sit ☐Stand ☐Sit & Stand My Health is: ☐Good ☐Fair ☐Poor

Best time/place to reach you: _____Family Physician:_____ Phone #: (____) _____

☐ Single ☐ Married Other_____ Whom may we thank for referring you? _____

EMERGENCY CONTACT & PRIVACY INFORMATION

Name: _____ Relationship: _____ Phone#: (___) _____

Can we leave messages at any of the above listed numbers: □Yes □No If No please indicate specific contact number:_____

Names of family/friends who have guardian's authorization to bring in the patient when guardian is absent: _____

PRIMARY INSURANCE

Name of Person Responsible for Account :_____ Phone # (_____) _____

Relation to Patient:_____ Social Security#:_____ Date of Birth: _____

Subscriber's Address_____
(street, city, state, zip code)

Subscriber Employed by:_____ Business Phone #: (____) _____

Insurance Co._____ Contract#:_____ Subscriber#: _____ Group#: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No Subscriber Name : _____

Address:_____ Phone #: (_____) _____
(street, city, state, zip code)

Social Security #: _____ DOB: _____ Relation to Patient: _____

Subscriber Employed by: _____ Business Phone#: (____) _____
(street, city, state, zip code)

Insurance Co._____ Contract#:_____ Subscriber#: _____ Group#: _____

CONSENT

I certify that the above and attached information is true and correct to the best of my knowledge. I give permission to *Dr. Gretta Shara* to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of my or my child's condition. As a representative of myself or as a guardian, I give authorization of the above listed patient to receive medical and/or surgical care and treatment by *Dr. Gretta Shara* at *Armada Foot and Ankle Clinic*.

Print Patient Name: _____ Signature of Patient/Guardian: _____ Date: _____

PODIATRIC HISTORY: **height:_____** **weight:_____** **shoe size:_____**

What is the chief complaint for which you came to be treated (Include foot, ankle, knee, thigh, hip, and back complaint) ? _____
_____ Date of Occurrence: _____

Related to: ☐Work ☐Auto ☐Accident ☐N/A Do you think you might be pregnant: ☐N/A ☐Yes ☐No

Previous Podiatrist Name & last visit: _____ Have you ever worn orthotics/arch supports: ☐Yes ☐No

Caffeine: Quantity _____ *Alcohol:* ☐None ☐Rarely ☐Moderately ☐Daily ☐Quit *Smoking*: Packs/day & #years:_____

Athletic/exercise activities in which you participate, please list and indicate frequency: _____
_____

Are you subject to prolonged bleeding or healing difficulties: ☐Yes ☐ No Do you bruise easily? ☐Yes ☐No

Family History:

List relationship to you of family members who have had: Arthritis: _____ Cancer: _____
Circulatory Problems: _____ Diabetes: _____ Foot Problems: _____ Heart Problems: _____

MEDICAL HISTORY:

History Of: Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low/High Blood Pressure	Special Diet
Anemia	Chest Pain	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chemical Dependency	Gout	Neuropathy	Stomach Ulcers
Ankle Pain	Cancer	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in Ankles/Feet
Artificial Heart Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints	Depression/Nervous Problem	Hemophilia	Radiation Treatment	Thyroid Disorder
Asthma	Diabetes	High Cholesterol	Rash	Tuberculosis
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Varicose Veins
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Venereal Disease
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Weight Loss, unexplained

Sensation History: ☐Night Pain ☐Burning ☐Tingling ☐ Swelling ☐Cramps/Numbness in Feet or Legs ☐Calf Pain

Pain Level: Please circle the number on the pain scale that best represents your level of pain at this moment.
0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10
(Zero: No Pain) (Ten: Worst Possible Pain)

Past Surgical Procedures/other Hospitalization (please attach additional list if they apply):

Surgical History	Date	Hospitalization History	Date
_____	_____	_____	_____
_____	_____	_____	_____

Previous Blood Transfusions: ☐Yes ☐ No Exposure to Hepatitis: ☐Yes ☐ No

Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: _____
_____

Pharmacy Name: _____ Location: _____ Phone #: _____

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: _____	Anticoagulants: _____	Aspirin: _____
Codeine: _____	Demerol: _____	Iodine: _____
Local Anesthetics: _____	Novocain: _____	Penicillin: _____
Seafood: _____	Sulfa: _____	Other: _____

Print Patient Name:_____ Signature of Patient/Guardian:_____ Date:_____