CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
ANNUAL UPDATE

Patient Name: _____ **Appointment Date**: _____

Referring Physician (Name & Practice Location):_____

Preferred Pharmacy & Location:_____

1. **Describe your foot/ankle problem(s) (including left, right or both) :**

_____

_____

2. How long have you had this problem? _____

3. Are you experiencing pain? ☐ No ☐ Yes (if yes, please answer the following)

How long have you had pain? _____ days _____ weeks _____ months _____ years

Describe the type of foot pain: ☐Burning ☐Aching ☐Sharp ☐Stabbing ☐Throbbing ☐Pins/Needles ☐Numb

Pain severity 0 = none, 10 = very severe (please circle) 0 1 2 3 4 5 6 7 8 9 10

Exact location (if possible): _____

How frequent is the pain? ☐ Constant ☐ Daily ☐ Often ☐ Occasionally ☐ Rarely

Pain is often experienced with: ☐ Walking/Standing ☐ Resting ☐Certain Shoes ☐Pressure ☐With Activity

The pain is made worse by: _____

Do you feel numbness in your feet? ☐ Yes ☐ No Tingling? ☐ Yes ☐ No

Social History

4. If female, are you currently pregnant? ☐ No ☐ Yes ☐ Maybe

5. Do you smoke cigarettes? ☐ No ☐ Yes If so, for how many years? _____ How many packs per day? _____

6. Are you a former smoker? ☐ No ☐ Yes If so, for how many years? _____ How many packs per day? _____

7. **If you have diabetes, please answer the following questions:**

Do you check your blood sugar at home? ☐Yes ☐ No If so, how often? _____ Last result: _____

Last Hemoglobin A1C Value: _____ Date: _____ Drawn where? _____

PLEASE COMPLETE BOTH SIDES

Patient Name: _____ **Appointment Date**: _____

8. **Have you had any surgeries or hospitalizations in the past two years?** ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

_____

9. **Allergies** (If yes, what type of reaction?) ☐ NONE

☐ Penicillin _____
☐ Other Antibiotics (which ones?) _____
☐ Aspirin _____
☐ NSAIDS (Ibuprofen/Aleve): _____
☐ Pain Medication (which ones?): _____
☐ Latex _____
☐ Sulfa Drugs_____
☐ Nickel/Other Metals _____
☐ Surgical Implants _____
☐ X-ray Contrast Dye _____
☐ Other _____

10. **List all Medications/vitamins with dose & directions:** ☐ **NONE** ☐ **I have attached a list**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

11. **Do you take the following?** ☐ Tylenol ☐ Advil, Ibuprofen, Aleve or Motrin

If so, how much? _____ How often? _____

12. **Vaccines** Have you had a Flu Vaccine? ☐ Yes ☐ No If Yes, approximately when? _____

Have you had a Pneumonia Vaccine? ☐ Yes ☐ No If Yes, approximately when? _____

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

Patient Name: _____ **Appointment Date**: _____

13. **Family History** (Who in your family has had these medical problems?): ☐ NONE

☐ Diabetes _____ ☐ Heart Disease_____ ☐ Kidney Disease _____

☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____

☐ Arthritis _____ ☐ Bleeding Disorder _____ ☐ Cancer_____

☐ Other Family History: _____

14. **VITAMIN D LEVEL** Have you had your Vitamin D Level checked? ☐Yes (☐ normal ☐ abnormal) ☐No ☐Unsure

15. **Past Medical History:** (Check those that apply to you) ☐ NONE

☐ Skin Cancer	☐ Thyroid Disorder
☐ Other Cancer (where?)	☐ Stomach Ulcer
☐ Vision Impairment	☐ Hiatal Hernia
☐ Hearing Loss	☐ GERD
☐ Lung/Respiratory Disorders	☐ Cirrhosis
☐ Mitral Valve Prolapse	☐ Kidney Disease
☐ Past Heart Attack (when?)	Do you receive kidney dialysis? ☐ Yes ☐ No
☐ Arrhythmia	☐ Diabetes
☐ Stroke	# Years:
☐ History of Blood Clots	☐ Gout
☐ Other Bleeding Disorders	☐ Rheumatic Fever
☐ High Blood Pressure	☐ Osteoarthritis
☐ Elevated Cholesterol	☐ Other Arthritis
☐ Anemia	☐ Seizure Disorder
☐ Depression or Mood Swings	☐ HIV/AIDS
☐ Fibromyalgia	☐ Hepatitis
☐ Neuropathy or Nerve Damage	☐ Tuberculosis
☐ Other:	☐ History of MRSA Infection

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.

Signature: X_____ **Date:** _____

Patient or Personal Representative

To be used by Carolina Foot & Ankle Staff:

BP (sitting): _____/_____ Pulse _____/min (Reg. Irreg.) Resp. _____/min Temp: _____°F

Height _____ Weight_____ If over 65, Falls? _____

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
DEMOGRAPHICS

Patient's Last Name: _____ **First:** _____ Middle Int: _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Gender: _____ **Marital Status:** ☐ Single ☐ Married ☐Widowed ☐Divorced ☐Legally Separated

Race: ☐ White ☐Black ☐Hispanic ☐Asian ☐Native American ☐Other: _____

Ethnicity: ☐Hispanic ☐ Non Hispanic **Preferred language:** _____

Social Security: _____ **Date of Birth:** _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone:** _____

Primary Care Doctor's Practice Name: _____

Email Address: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Who carries the insurance? ☐The patient ☐ Other (Name): _____ DOB: _____

How did you hear about our practice? _____

Is the patient in a facility (ex: nursing home)? Name: _____ Phone: _____

Responsible Party

If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible Party's Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, whom do we contact? _____

Home: _____ Cell: _____ Work: _____

If you would like to update the list of people that we can talk to about your medical care or who can pick items up for you, please ask for a new HIPAA form.

I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

Signature: X_____ **Date:** _____

Patient or Personal Representative