

CHIEF COMPLAINT

NAME _____ **DATE** _____

How do you assess your present general health?

Excellent [] Good [] Fair [] Poor []

What brings you into our office today? **Chief Complaint? Specifically** – left/right, heel, ankle, arch, which toe, etc. _____

How long have you had this problem? _____

List other treatments or consultations with date _____

What type of sensation do you experience when painful? (Ex: Stabbing, Sharp, Burning, Aching Pain) _____

Is this the result of an injury? (yes or no): _____ Date of Injury: _____

Explain Injury: _____

Chris Seuferling, DPM
7940 SE Division Suite E ♦ Portland, Oregon 97206
Phone (503) 775-5846 ♦ Fax (503) 775-8054

MEDICAL HISTORY REVIEW

NAME _____ DATE _____

Medical History: Do you have or have you ever had any of the following problems?

Please answer all questions. **Yes** **No**

Please answer all questions. **Yes** **No**

Diabetes.....

*If yes, when were you diagnosed? _____

Neuropathy.....

*If yes, where? _____

Retinopathy.....

Kidney Disease.....

Liver Disease.....

*If yes, type? _____

Hypothyroidism.....

Hyperthyroidism.....

Stomach Ulcers.....

(GERD/Reflux).....

Epilepsy/Seizures.....

Arthritis

*If yes, type? _____

*Joints involved? _____

Osteoporosis.....

Back Problems.....

*If yes, type? _____

High blood pressure.....

High Cholesterol.....

Heart problems.....

*If yes, type? _____

Previous heart attack.....

*If yes, when? _____

Previous Stroke.....

*If yes, when? _____

Asthma.....

Lung Disease.....

*If yes, what type? _____

Gout.....

*If yes, when was last attack? _____

*Joints involved? _____

Knee Pain/Problems.....

*If yes, type? _____

Hip Pain/Problems.....

*If yes, type? _____

Bleeding Tendency.....

Blood clots.....

*If yes, where? _____

Venous Insufficiency.....

Lymphedema.....

Cancer/Tumor.....

*If yes, where? _____

*Malignant or Benign? _____

Depression.....

Mental/Emotional Disorder.....

*If yes, type? _____

Foot/Ankle Ulcers or Wounds.....

*If yes, when? _____

*Was surgery/amputation required? _____

Prior foot/ankle injuries or fractures?.....

*If yes, type? _____

Please list any other medical conditions you have:

Please list all hospitalizations and surgeries: (Including any prior foot/ankle surgery)

Any problems with anesthesia from prior surgeries? Yes No If yes, please describe nature of problem:

Please list any family history of health problems. (Ex: Father=Diabetes Uncle=Arthritis) (Alive/Deceased?)

Social History:

Do you smoke? Yes No If yes, how many packs per day? _____ # of years _____
 Do you drink? Yes No If yes, how often? Rarely Socially Daily Heavy
 Do you exercise? Yes No If yes, how often and what type? _____
 Need assistance to walk? Yes No If yes, type? (i.e.; cane, walker, etc) _____
 Do you drive? Yes No
 Do you live alone? Yes No
 Type of facility you live in? (i.e.; own home, apt, assisted living, etc) _____
 Do you require a caregiver? Yes No If yes, who provides care and how often? _____
 Your Occupation: _____ How many years? _____
 How often does your job require you to be on your feet? Always Often Sometimes Rarely Never
 Does your job require you to wear certain shoes? (i.e.; boots, steel toed, dress, heels, etc) Yes No
 *If yes, what is the requirement? _____
 What type of shoes do you normally wear? (sneakers, walking shoes, sandals, variety) _____
 When at home, how often do you have shoes or sandals on? Always Often Sometimes Rarely Never
 Please list any hobbies/interests you have: _____

Other pertinent information: _____

Review of Systems: Do you have or have you ever had any of the following problems?

Please answer ALL questions.	<u>Yes</u>	<u>No</u>	Please answer ALL questions.	<u>Yes</u>	<u>No</u>
Weight change in last year..	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing.....	<input type="checkbox"/>	<input type="checkbox"/>
Serious ear/eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/abdominal pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen gland/unusual lumps	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Racing heart/skipped beats.	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation/diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/tightness.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst.....	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/leg swelling.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/tiredness.....	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling.....	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain/swelling.....	<input type="checkbox"/>	<input type="checkbox"/>	Heal slowly from wounds or sores	<input type="checkbox"/>	<input type="checkbox"/>
Frequent cough/wheezing...	<input type="checkbox"/>	<input type="checkbox"/>	Fractured/broken bones.....	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contacts...	<input type="checkbox"/>	<input type="checkbox"/>	Hep C / HIV / AIDS concerns....	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Balance/falling issues.....	<input type="checkbox"/>	<input type="checkbox"/>

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Lacamas Family Foot & Ankle
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 Vancouver, WA 98683
 Phone (360) 696 - FOOT

PATIENT INFORMATION

NAME _____ DATE _____
 First M.I. Last
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ BUSINESS PHONE _____ SOCIAL SECURITY # _____
 AGE _____ DATE OF BIRTH _____ MARITAL STATUS S M W D SEP SEX: M / F SHOE SIZE: _____
 PERSONAL PHYSICIAN _____ HOW DID YOU HEAR ABOUT US? _____
 PATIENT'S EMPLOYER _____

PARENT OR SPOUSE (If Married)

NAME _____ RELATIONSHIP _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____
 SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX M F _____
 EMPLOYER _____

SOMEONE NOT LIVING WITH YOU IN CASE OF AN EMERGENCY

NAME _____ RELATIONSHIP _____ PHONE # _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID # _____ GROUP # _____
 SECONDARY INSURANCE _____ ID # _____ GROUP# _____

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

YES NO I hereby authorize payments directly to the physician of the surgical and / or medical benefits
 YES NO I also understand I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:

YES NO I hereby authorize release of information for insurance claim purposes. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV, and aids.

HIPPA:

YES I have been provided the opportunity to read the 'Notice of Patient Privacy Practices'.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signed _____ Date _____
 (Responsible Person or Parent/Guardian if minor)

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Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: _____

Date: _____

Circle "Yes" or "No":

- | | Test for PAD | | |
|--|--------------|----|--------------------------|
| 1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? | Yes | No | <input type="checkbox"/> |
| 2. Do you experience any pain at rest in your lower leg(s) or feet? | Yes | No | <input type="checkbox"/> |
| 3. Do you experience foot or toe pain that often disturbs your sleep? | Yes | No | <input type="checkbox"/> |
| 4. Are your toes or feet pale, discolored, or bluish? | Yes | No | <input type="checkbox"/> |
| 5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? | Yes | No | <input type="checkbox"/> |
| 6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? | Yes | No | <input type="checkbox"/> |
| 7. Have you suffered a severe injury to the leg(s) or feet? | Yes | No | <input type="checkbox"/> |
| 8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? | Yes | No | <input type="checkbox"/> |

Patient Signature: _____

Physician Signature: _____

Date : _____