Chris Seuferling, DPM
Foot and Ankle
Physician

Thank you for choosing to see Dr. Chris Seuferling, DPM.

We welcome you to our practice. We are pleased that you have selected us to care for your foot & ankle needs and we look forward to your initial visit. We pride ourselves on making your visit a pleasant experience, while providing you with quality podiatric care.

Here is a list of some of the problems we treat:

- Achilles Tendonitis
- Ankle Instability
- Ankle Sprains
- Arthritic Foot & Ankle Care
- Athlete's Foot
- Bunions
- Calluses
- Corns
- Crush Injuries
- Diabetic Foot Care
- Flat Feet
- Fungal Toenails
- Geriatric Foot Care
- Hammertoes
- Heel Spurs
- Ingrown Toenails
- Injuries
- Neuromas
- Plantar Fasciitis
- Warts

Please feel free to call our office at (503) 775-5846 if you have questions regarding participating insurance plans, appointments, scheduling, or any other concerns.

Thank you again for your patronage & we look forward to meeting you.

Mt. Tabor Podiatry
7940 SE Division, Suite E
Portland, OR 97206
Phone: (503) 775-5846
Fax (503) 775-8054

Scappoose Podiatry
52485 SW 1st Street
Scappoose, OR 97056
Phone: (503) 775-5846
Fax (503) 775-8054

PATIENT INFORMATION

NAME_____ **DATE**_____
First M.I. Last
ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

PHONE_____ **SS#** _____ **EMAIL:**_____

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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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:_____

_____

_____

_____

_____

_____

_____

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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**

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…….. ☐ ☐
MRSA ……. ☐ ☐

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? _____

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

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

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Patient Name:_____ DOB_____ Date:_____

Pharmacy Name:_____ Pharmacy Phone # _____
Are you on a pain management contract? Yes/no Dr's Name:

Medication	Dosage	Frequency	Route

Drug Allergies and Reactions: (EX: Penicillin=hives,itching) (Include any allergies to local anesthetics, tapes, betadine, ointments, or latex)

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