



PATIENT HISTORY

GENERAL INFORMATION

Name _____
Last First Middle/Maiden Name you Prefer

Address _____
Street City State/Zip

Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

E-Mail Address _____

Age ____ **Sex** ____ **Date of Birth** ____/____/____ **Social Security#** _____

Height ____ **Shoe Size** ____ **Race** ____ **Language** ____ **Ethnicity** ____ **Weight** ____

Married ____ (**Spouse's Name** _____) (**Spouse's Email** _____)
Single ____ **Widowed** ____ **Divorced** ____

Patient's Employer: _____ **Work Phone:** _____

Work Address: _____

Spouse's Employer: _____ **Work Phone:** _____

Work Address: _____

RESPONSIBLE PARTY INFORMATION *(If different than patient)*

Name: _____

Date of Birth ____/____/____ **Social Security #:** _____

Address: _____

Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

Employer: _____



FOOTHILLS PODIATRY
707 North Morgan Street Shelby, NC 28150 | **Phone:** (704) 487-6672
Email: info@foothillspodiatry.com | **Web:** www.foothillspodiatry.com

IF ASSIGNMENT IS TAKEN, I AUTHORIZE MY INSURANCE/MEDICARE BENEFITS TO BE PAID DIRECTLY TO FOOTHILLS PODIATRY, P.A. AND AUTHORIZE RELEASE OF INFORMATION ACQUIRED IN THE COURSE OF TREATMENT IN ORDER TO PROCESS CLAIMS. I AM FINANCIALLY RESPONSIBLE FOR ALL RENDERED SERVICES.

I ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE PHYSICIAN. BY SIGNING BELOW, I AGREE TO THE ABOVE AND GRANT FOOTHILLS PODIATRY, P.A. PERMISSION FOR EVALUATION AND TREATMENT OF MY MEDICAL CONDITION.

***** PAYMENT IS EXPECTED AT TIME OF SERVICE *****
WE WILL FILE YOUR INSURANCE AS A COURTESY FOR YOU

Date: ____/____/____ **Signature:** _____

PLEASE CHECK METHOD OF PAYMENT: _____ **-Cash** _____ **-Check** _____ **-Credit Card**

PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD(S).
PLEASE READ AND COMPLETE ALL PAGES. THANK YOU.

HEALTH HISTORY

Acct#: _____

Date ____/____/____ **Male / Female** **Referred By:** _____

Name _____ **DOB** ____/____/____ **Age** ____ **Family MD:** _____

What is the reason for this visit? _____

Location (Right or Left / Area): _____

When did it begin? _____

Describe pain (sharp, dull, constant, etc.): _____

Injury? _____ **Date & Time of Injury:** _____

Anything aggravates or alleviates it? _____

Any treatment (self or Dr.)? _____

List all current Medications (Name & Dosage): _____

Pharmacy Name & Location: _____

ALLERGIES & TYPE OF REACTION: (Example: Codeine-Rash)

| | | |
|-------------------|---------------------|----------------|
| None _____ | Penicillin _____ | Novocain _____ |
| Codeine _____ | Sulfa _____ | Iodine _____ |
| Aspirin _____ | Adhesive tape _____ | IVP Dye _____ |
| Anesthetics _____ | Neosporin _____ | Other _____ |
| Foods _____ | Latex _____ | |

MEDICAL CONDITIONS - YOU have or had in the past.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Aids (HIV) | <input type="checkbox"/> Gout | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Breast Feeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver DS-Hepatitis | <input type="checkbox"/> Thyroid Disorder | |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Bowel disorder | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nerve Problems | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Fibromyalgia | |

List All Surgeries & Year: _____

List All Serious Illness/Injuries & Year: _____

HEALTH HABITS (USE & AMOUNT)

- | | |
|---|--|
| <input type="checkbox"/> Caffeine _____ | <input type="checkbox"/> Tobacco _____ |
| <input type="checkbox"/> Drugs _____ | <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Other _____ | |

Occupation: _____ **Hobbies:** _____

FAMILY HISTORY:

| Relation | Age | Age of Death | Cause of Death |
|-----------------|------------|---------------------|-----------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Brother's | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Sister's | _____ | _____ | _____ |
| | _____ | _____ | _____ |

MEDICAL CONDITIONS THAT FAMILY MEMBERS HAVE:

| Disease | Relationship (M-mother, F-father, B-brother, S-sister) |
|-----------------------|---|
| ___ Arthritis-Gout | _____ |
| ___ Asthma | _____ |
| ___ Cancer | _____ |
| ___ Addictions to: | _____ |
| ___ Diabetes | _____ |
| ___ Heart-Stroke | _____ |
| ___ High Blood Press. | _____ |
| ___ Kidney Disorder | _____ |
| ___ Tuberculosis | _____ |
| ___ Other: | _____ |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor, nurse or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I also give permission to release medical records to the referring doctor insurance company or employer.

Signature: _____ **Date:** ____/____/____

Reviewed by: _____ **Date:** ____/____/____

Reviewed by: CJM _____ RAM _____ **Date:** ____/____/____



WELCOME TO OUR PRACTICE!

YOU WILL NEED TO BRING YOUR INSURANCE
CARDS AND MEDICATIONS WITH YOU ON YOUR
APPOINTMENT.

IF YOU DO NOT HAVE THEM WE WILL NEED TO
RESCHEDULE YOUR APPOINTMENT.

THANK YOU!