HILLSIDE
Foot&Ankle

PATIENT INFORMATION FORM (PLEASE PRINT)

Date: ___/___/___ Social Security #: _____

Patient Name: _____ _____ ___ Date of Birth: ___/___/___ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____-_____ Yes No May we leave a message?
Cell Phone: (_____) _____-_____ Yes No May we leave a message?
Email: _____
If you would like us to release medical information to family members or other individuals, please list their name and relationship: _____ _____
_____ _____

Primary Language: _____ Ethnicity: ___Not Specified ___Hispanic/Latino ___Not Hispanic / Latino
Race: ___White ___Amer. Indian/Alaska Native ___Asian ___Black/African Amer. ___Native Hawaiian/Pacific Is.
___Not Specified

Emergency Contact: _____ Relationship: _____ Phone #: (___) ____-_____

Primary Care Doctor: _____ Date last seen: _____ Pharmacy: _____

Who is responsible for payment? _____ Relationship to patient? _____
Address: _____ City/State: _____ Zip: _____
Phone #: (_____) _____-_____ Birthdate: _____ Social Security # _____

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____ Relationship: _____ Phone #: (___) ____-_____

Whom may we thank for referring you to us? _____

Insurance Information

Primary Insurance Company Name: _____
Policy #: _____ Group #: _____
Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Secondary Insurance Company Name: _____
Policy #: _____ Group #: _____
Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ____ packs/day for ___yrs

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____ Phone #: (_____) _____-_____
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

OVER

Family History

Please indicate, using the following letters: **F**(Father), **M**(Mother), **B**(Brother), **S**(Sister), **D**(Daughter), **C**(Son) who in your family has a history:

Diabetes_____ Cancer_____ Heart Disease_____ High Blood Pressure_____
Stroke_____ Coronary Artery Disease_____ Thyroid Disease_____
Rheumatoid Arthritis_____ Other _____

Your Medical History

Height:_____ Weight:_____ Shoe Size:_____

Allergies: ☐ None Known ☐ Penicillin ☐ Medications _____
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Anesthesia _____
☐ Foods _____ ☐ Other _____

Place a check mark in the box to indicate if you have ever had any of the following?

	Yes	No		Yes	No		Yes	No
Acid Reflux			Fibromyalgia			Mitral Valve Prolapse		
Anemia			Gout			Neuropathy		
Arthritis			Heart Attack			Open Sores		
Asthma			Heart Disease/Failure			Pneumonia		
Back Trouble			Hepatitis			Polio		
Bladder Infections			HIV+/AIDS			Rheumatic Fever		
Abnormal Bleeding			High Blood Pressure			Skin Disorder		
Blood Clots			High Cholesterol			Sleep Apnea		
Blood Transfusion			Kidney Disease			Stomach Ulcers		
Bronchitis/Emphysema			Liver Disease			Stroke		
Cancer			Low Blood Pressure			Thyroid Disease		
Diabetes			Migraine Headaches			Tuberculosis		
Other Conditions:								

List all medications and dosages you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date	Type of Surgery	Date

List all prior hospitalizations (other than for surgery)in the last 12 months:

Reason	Date	Reason	Date	Reason	Date