Welcome to our office. In order for us to better serve your foot and ankle health needs, please complete this questionnaire. This will enable us to get to know you better so that we may provide you with quality care.

PATIENT INFORMATION:

Name _____ Date of Birth _____
Name of Parent (If Minor): _____
Address _____ City/State _____ Zip _____
Social Security Number: _____ Home Phone ( ) _____
Cell Phone ( ) _____
Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Married _____ Single _____ Divorced _____ Widowed _____

Emergency Contact: _____ Relationship: _____ Phone: _____
Pharmacy used: _____ Phone: _____
Personal Physician: _____ Phone: _____

INFORMATION ON PRIMARY INSURED PERSON: Self ____ Spouse ____ Parent ____ (Check One)

Name of Primary Person: _____ Primary's Address: _____
Primary's Date of Birth: _____ Primary's Soc. Sec. Number: _____
Primary's Employer: _____
Primary's Business Address: _____ Business Phone _____
Did a Physician refer you to our office? _____ If so, Dr. _____
Referring Physician Phone No. _____

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____
Insurance Company_____ Facebook_____ Other_____

MEDICAL INSURANCE INFORMATION

(PLEASE PRESENT YOUR INSURANCE CARD TO RECEPTIONIST FOR COPYING)

Patient or Guardian agrees to ALL of the following:

I agree to be responsible for payment of services rendered by Instride Wilson Podiatry Associates for the above named patient.
I understand that insurance, if any, may be filed on my behalf and that my account will be subject to collection turnover if not paid in a timely manner.
I understand that all laboratory tests will be billed by an outside laboratory and not from the office of Instride Wilson Podiatry Associates.
I authorize the release of any medical or other information necessary to process medical claims.
I authorize payment of medical benefits to physician or supplier of Instride Wilson Podiatry Associates.
I hereby give permission to Dr. Blackwell and staff to evaluate and administer treatment and perform such minor procedures that are necessary to diagnose and treat my foot or ankle problem.

Date: _____ Signature of Patient or Guardian: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____ _____
Patient Name (please print) Parent or Authorized Representative (if applicable) Date

_____
Signature

PLEASE COMPLETE ALL 3 PAGES

DATE: _____

Patient Name: _____ **Age:** _____ **Sex**: _____ **Race:** _____Weight:_____

1. Which foot or leg is involved? _____ Where is the pain located? _____
   What type of pain are you having? _____

2. How long has your problem existed? _____

3. Was an **accident** involved? _____ If so: Date: _____ Time: _____ Place: _____
   How did accident occur? _____
   _____

4. Do you remember any event, activity or particular shoewear that seemed to **trigger** your symptoms?
   _____

5. Have you noticed anything that **aggravates** your problem? _____
   What have you done that makes your problem **better**? _____

6. **Circle one underlined description in each question** that best describes your symptoms.
   Was the onset of your symptoms gradual or sudden?
   Have your symptoms been persistent or do they seem to "come and go"?
   Has the problem gotten worse, better or stayed the same?

7. If another doctor has rendered professional care for this problem, please name this doctor.
   Dr. _____ When? _____

8a. **MEDICAL HISTORY/REVIEW OF SYSTEMS:**
Please place a check by the following doctor diagnosed conditions that you have or have had in the past:

_____Diabetes (insulin, tablets, diet-controlled)
_____High Blood Pressure
_____Heart Problems (heart attack, angina, CAD, CHF)
_____Heart Murmur or Valvular Problems
_____Stroke (CVA, TIA)
_____Lung Problems (emphysema, asthma, COPD)
_____Kidney Problems (stones, dialysis, infection)
_____Liver Problems
_____High Cholesterol
_____Hardening of the Arteries
_____Bleeding Disorders
_____Blood Clots (phlebitis, deep vein thrombosis)
_____Anemia (sickle cell, iron deficient, pernicious, etc.)
_____Glandular Disorders (thyroid, pituitary, etc.)
_____Skin Disorders (psoriasis, xerosis, eczema, etc.)
_____Keloid Scar Formation
_____Artificial Jts. or Heart Valve Implants

_____Cancer (where?, location)_____
_____Hernia (hiatal, inguinal, umbilical)
_____Gastric or Intestinal Ulcer
_____Esophageal Reflux (GERD)
_____Intestinal Disorders (irritable bowel syndrome, diverticulitis, diverticulosis, etc.)
_____Chronic Constipation
_____Chronic Diarrhea
_____Glaucoma
_____Macular Degeneration
_____Arthritis (osteo-, rheumatoid, gout, psoriatic, etc.)
_____Lupus
_____Scleroderma
_____Hepatitis (A, B, or C)
_____Tuberculosis (active, non-active)
_____AIDS/HIV Positive

Date of Last Physical/Medical Check-up _____
Other Medical Problems: _____

Name: _____

9. List all **previous surgeries** you have had. Please include dates.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

10. List any **recent hospitalizations** you have had in the last 3 years. Please include dates.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

11. List all **medications** that you take on a daily basis, how much you take each day and for what conditions you take the medication. (Please include birth control pills or doses of aspirin.)

MEDICINE: Example: (Crestor)	DOSAGE/HOW OFTEN: (5 mg/once a day)	FOR WHAT CONDITION: (high cholesterol)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

12. Are you **allergic** to any drugs or medications? Yes _____ No _____
LIST: _____
_____
Are you allergic to: Any foods? _____ Adhesive tape? _____ Iodine? _____

13. Do you smoke or use tobacco in any form? _____
How many packs per day? _____ How many years have you smoked? _____

14. Have you experienced any Alcohol, Drug or Chemical dependency problems in the past or in the present? No_____ Yes _____ (Explain) _____

15. Do you drink alcohol? _____. How much? _____