Mountain Podiatry, PA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

PATIENT HEALTH HISTORY

Name _____ Age_____ Height_____ Weight_____ Last Blood Pressure _____/_____

(Following are government mandated questions): Race _____ ☐ do not wish to answer
Ethnicity _____ ☐ do not wish to answer

Family Doctor:_____ Last Visit:_____ Specialist:_____

Allergies: NONE TAPE (what type) Rubber/Latex Seasonal Food Other_____

Medication Allergies:_____ _____ _____

List of current medications: (Continue on back if list is longer than space available)

_____ _____

_____ _____

_____ _____

Have you received a flu shot? NO YES

Have you received a pneumonia shot? NO YES

Pharmacy used: _____

Location/Phone #_____

Surgeries- Indicate what type/year:

Hospitalized (not surgeries) Indicate why/year

_____ _____

_____ _____

_____ _____

What specific problem with your foot brings you to the Doctor today? _____

Have you ever been to a Podiatrist before? NO YES For what problem? _____

FOOT AND ANKLE

Have you ever broken a bone in your foot or ankle? NO YES
Where _____ When _____

Have you had a problem with this area since that time?
If so, what problem? _____

What is your normal shoe size? _____

Circle any of these that you have had:

Ankle Pain	Foot Cramps
Athlete's Foot	Heel Pain
Bunions	Ingrown Toenail
Corns	Plantar Warts
Calluses	Swollen Feet
Flat Feet	Tired Feet

What type of shoe do you normally wear? _____

Do you go barefooted? (Circle one) Never Rarely Occasionally Often As much as I can

Do you smoke? NO YES Amount Per Day _____ How Long? _____ Have you EVER smoked? NO YES

Do you drink alcohol? NO YES Amount Per Day _____ Beer Wine Liquor How Long? _____

I hereby give permission to Drs. Hyman, Wadington, and Grant and to whomever they designate to administer treatment, and to perform such procedures as they may deem necessary in the diagnosis and/or treatment of the extremity condition.

Signature of Patient or Legal Guardian_____ Date_____

Name: _____ Date of Birth: _____ Date: _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

HEENT
- ◯ Difficulty Swallowing
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Hearing Problems
- ◯ Thyroid Problems
- ◯ Other:

CARDIOVASCULAR
- ◯ Chest Pain/Angina
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ High Cholesterol
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Abnormal EKG
- ◯ Swellling of feet/Ankles
- ◯ Abnormal Heart Beat
- ◯ Artificial Heart Valve
- ◯ Pacemaker
- ◯ Blood Clot in Leg
- ◯ Other:

SKELETAL/MUSCULAR
- ◯ Gout
- ◯ Arthritis
  TYPE: _____
- ◯ Sore that does not heal
- ◯ Limited Joint Motion
- ◯ Back Problems
- ◯ Other:

LIVER
- ◯ Hepatitis
- ◯ Jaundice
- ◯ Other:

NEUROLOGICAL
- ◯ Numbness in Legs/Feet
- ◯ Fainting/Dizziness
- ◯ Seizure
- ◯ Epilepsy
- ◯ Stroke
- ◯ Other:

RESPIRATORY
- ◯ Asthma
- ◯ Lung Disease/COPD
- ◯ Emphysema
- ◯ Abnormal Chest Xray
- ◯ Shortness of Breath
- ◯ Use of Oxygen at Home
- ◯ Tuberculosis
- ◯ Blood Clot in Lung
- ◯ Other:

GASTROINTESTINAL
- ◯ Abdominal Pain
- ◯ Hiatal Hernia
- ◯ Unexplained Weight Loss
- ◯ Heartburn
- ◯ GERD
- ◯ Stomach Ulcer
- ◯ Other:

MENTAL HEALTH
- ◯ Depression
- ◯ Panic Attacks
- ◯ OCD
- ◯ Schizophrenia
- ◯ ADD
- ◯ Bipolar
- ◯ Other:

GENITOURINARY
- ◯ Difficulty Urinating
- ◯ Frequent Infections
- ◯ Prostate Problems
- ◯ Kidney Problems
- ◯ Dialysis
- ◯ Other:

HEMATOLOGICAL
- ◯ Anemia
- ◯ Bleeding Disorder
- ◯ Hemophilia
- ◯ Sickle Cell Anemia
- ◯ HIV/AIDS
- ◯ Other:

CANCER
_____ YES _____ NO

WHAT TYPE:

WHEN:

ANY OTHER CONDITIONS?

*** **ARE YOU A DIABETIC?** _____ YES _____ NO

*** **Do you need antibiotics before cleanings at the dentist?** _____ YES _____ NO

PLEASE LIST ANY FAMILY MEMBERS (BLOOD RELATIVES) THAT HAVE ANY OF THE FOLLOWING:

Diabetes Cancer Gout Heart Disease High Blood Pressure Other