
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? _____

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 _____

Circle any of these that you have had:

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

Name: _____ Date of Birth: _____ Date: _____

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

<p><u>HEENT</u></p> <p><input type="radio"/> Difficulty Swallowing</p> <p><input type="radio"/> Glaucoma</p> <p><input type="radio"/> Cataracts</p> <p><input type="radio"/> Hearing Problems</p> <p><input type="radio"/> Thyroid Problems</p> <p><input type="radio"/> Other:</p>	<p><u>CARDIOVASCULAR</u></p> <p><input type="radio"/> Chest Pain/Angina</p> <p><input type="radio"/> Heart Attack</p> <p><input type="radio"/> Heart Disease</p> <p><input type="radio"/> High Cholesterol</p> <p><input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> Low Blood Pressure</p> <p><input type="radio"/> Abnormal EKG</p> <p><input type="radio"/> Swelling of feet/Ankles</p> <p><input type="radio"/> Abnormal Heart Beat</p> <p><input type="radio"/> Artificial Heart Valve</p> <p><input type="radio"/> Pacemaker</p> <p><input type="radio"/> Blood Clot in Leg</p> <p><input type="radio"/> Other:</p>	<p><u>SKELETAL/MUSCULAR</u></p> <p><input type="radio"/> Gout</p> <p><input type="radio"/> Arthritis</p> <p>TYPE: _____</p> <p><input type="radio"/> Sore that does not heal</p> <p><input type="radio"/> Limited Joint Motion</p> <p><input type="radio"/> Back Problems</p> <p><input type="radio"/> Other:</p>	<p><u>LIVER</u></p> <p><input type="radio"/> Hepatitis</p> <p><input type="radio"/> Jaundice</p> <p><input type="radio"/> Other:</p>
<p><u>NEUROLOGICAL</u></p> <p><input type="radio"/> Numbness in Legs/Feet</p> <p><input type="radio"/> Fainting/Dizziness</p> <p><input type="radio"/> Seizure</p> <p><input type="radio"/> Epilepsy</p> <p><input type="radio"/> Stroke</p> <p><input type="radio"/> Other:</p>	<p><u>RESPIRATORY</u></p> <p><input type="radio"/> Asthma</p> <p><input type="radio"/> Lung Disease/COPD</p> <p><input type="radio"/> Emphysema</p> <p><input type="radio"/> Abnormal Chest Xray</p> <p><input type="radio"/> Shortness of Breath</p> <p><input type="radio"/> Use of Oxygen at Home</p> <p><input type="radio"/> Tuberculosis</p> <p><input type="radio"/> Blood Clot in Lung</p> <p><input type="radio"/> Other:</p>	<p><u>GASTROINTESTINAL</u></p> <p><input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> Hiatal Hernia</p> <p><input type="radio"/> Unexplained Weight Loss</p> <p><input type="radio"/> Heartburn</p> <p><input type="radio"/> GERD</p> <p><input type="radio"/> Stomach Ulcer</p> <p><input type="radio"/> Other:</p>	<p><u>MENTAL HEALTH</u></p> <p><input type="radio"/> Depression</p> <p><input type="radio"/> Panic Attacks</p> <p><input type="radio"/> OCD</p> <p><input type="radio"/> Schizophrenia</p> <p><input type="radio"/> ADD</p> <p><input type="radio"/> Bipolar</p> <p><input type="radio"/> Other:</p>
<p><u>GENITOURINARY</u></p> <p><input type="radio"/> Difficulty Urinating</p> <p><input type="radio"/> Frequent Infections</p> <p><input type="radio"/> Prostate Problems</p> <p><input type="radio"/> Kidney Problems</p> <p><input type="radio"/> Dialysis</p> <p><input type="radio"/> Other:</p>	<p><u>HEMATOLOGICAL</u></p> <p><input type="radio"/> Anemia</p> <p><input type="radio"/> Bleeding Disorder</p> <p><input type="radio"/> Hemophilia</p> <p><input type="radio"/> Sickle Cell Anemia</p> <p><input type="radio"/> HIV/AIDS</p> <p><input type="radio"/> Other:</p>	<p><u>CANCER</u></p> <p>_____ YES _____ NO</p> <p>WHAT TYPE:</p> <p>WHEN:</p>	<p>ANY OTHER CONDITIONS?</p>

*** 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