Athens Podiatry

Dr. Mauro Rossi Dr. Brad Castellano

Patient Information

Patient's Name:		Home Phone:	Emergency Contact #:	Age:
Address:	Apt:	Work Phone:	Social Security #:	Weight:
City:	State: Zip:	Mobile Phone:	Date Of Birth:	Height:
Employer:	Position:	Insurance Provider:	Insurance Number: ☐ HMO ☐ PPO	Sex:
Physician:	Referral: Yes No	Pharmacy:	Pharmacy Phone:	

Check all that apply — Walk constantly at your job: ☐ Retired: ☐ Disabled: ☐ Wheelchair Bound: ☐ Cane User: ☐ Orthotics: ☐

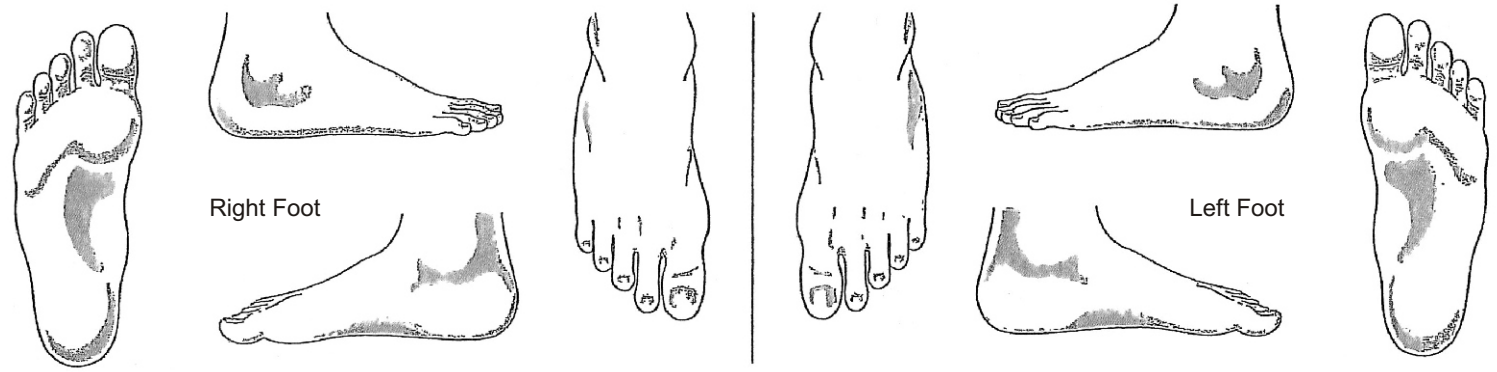
May we contact your physician regarding your health: ☐ Yes ☐ No

Problem 1:	Duration:
Pain Symptoms: (Circle All that Apply) No Pain Sharp Dull Burning Aching Throbbing	

Problem 2:	Duration:
Pain Symptoms: (Circle All that Apply) No Pain Sharp Dull Burning Aching Throbbing	

Foot Condition

Please use picture area to mark location(s) of concern.



Past Medical History

Check all that apply

Last Physician visit: ____/____/_____

- ☐ Alzheimer
- ☐ Anemia
- ☐ Arthritis
- ☐ - Lupus
- ☐ - Rheumatoid
- ☐ Blood Transfusion
- ☐ Cancer
  - Type
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Thyroid Condition
- ☐ Stroke
  - Year
- ☐ Heart Attack
  - Year
- ☐ Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
  - Type
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ - Emphysema
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ - Dialysis
- ☐ Keloid
- ☐ - Do You Scar
- ☐ Gout
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Psychiatric Disorders
- ☐ Depression
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin Disorders
- ☐ Psoriasis
- ☐ Hearing Disorder
- ☐ Osteoporosis
- ☐ Stomach Ulcers
- ☐ - Reflux
- ☐ Poor Circulation
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Swelling Legs
- ☐ Back Problems
- ☐ Burning Feet
- ☐ - Neuropathy
- ☐ Foot Ulcer
- ☐ Foot Infection
- ☐ - Amputation
- ☐ Blood Thiners
- ☐ - Coumadin
- ☐ - Plavix
- ☐ - Other
- ☐ Diabetes
  - ☐ - Insulin Controlled
  - ☐ - Oral Meds Controlled
  - ☐ - Diet Controlled
- ☐ Pregnant
  - - Physician
  - - Phone #

Other:

MEDICAL HISTORY *Check all that apply*

Surgical History
- ☐ Amputation
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Heart Pypass
- ☐ Heart Valve Replacement
- ☐ Pacemaker
- ☐ Lower Extremity Bypass
- ☐ Other

Family History
- ☐ Anemia
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Neurological Disorders
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Flatfeet
- ☐ Bunions
- ☐ Hammertoes
- ☐ Other
- ☐
- ☐
- ☐

Allergies
- ☐ None
- ☐ Betadine
- ☐ Sulfa
- ☐ Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Novocaine
- ☐ Lidocaine
- ☐ Penicillin
- ☐ Other
- ☐ Can you take a Z-Pack?

Social History
- ☐ Do you smoke
  - How Long
- ☐ Do you drink alcohol or beer
- ☐ - Light Use
- ☐ - Moderate Use
- ☐ - Heavy Use
- ☐ Do you use illegal drugs

Medication
I brought a medication list (as requested) ☐ Yes ☐ No ***- If not please enter all medications below***

CONTINUATION OF MEDICAL HISTORY *Check all that apply*

Constitutional Symptoms
- ☐ Good general health lately
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue

Eyes
- ☐ Eye disease or injury
- ☐ Wear glasses/contact lenses
- ☐ Blurred or double Vision

Ears/Nose/Mouth/Throat
- ☐ Hearing loss or ringing
- ☐ Swollen glands in neck

Cardiovascular
- ☐ Swelling of the feet, ankles, hands
- ☐ Chest pain or angina pectoris
- ☐ Palpitation
- ☐ Shortness of breath

Respiratory
- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Abdominal pain

Genitourinary
- ☐ Kidney stones
- ☐ Frequent urination

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Weakness of muscles, joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty walking

Integumentary (skin)
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins

Endocrine
- ☐ Skin becoming dryer
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance

Neurological
- ☐ Frequent/recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness/tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury

Psychiatric
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

Hematological/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Phlebitis
- ☐ Past Transfusion
- ☐ Enlarged glands

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Authorization: Benefits to Physician

☐ Yes ☐ No I hereby authorize payments directly to Athens Podiatry PC of surgical and/or medical benefits.

☐ Yes ☐ No I also understand that I am responsible for any portion of my bill NOT covered by the insurance company.

☐ Yes ☐ No I authorize the release of information for insurance claim purposes. This information may contain medical information pertaining to communicable or venereal disease, including gonorrhea, HIV and AIDS.

☐ Yes ☐ No I acknowledge that I was provided 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.

PRINT Name: Signature: Date:

Authorize release of your medical records:

Name: Relationship:

Name: Relationship:

Name: Relationship:

I certify that the information of this patient information form is correct to the best of my knowledge. I will not hold the doctor or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I give permission to the doctor/staff to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my foot, ankle and leg.

Patient Signature: Parent authorized Rep: Date: