Highpoint FOOT & ANKLE Center
For every Season of your Life

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___ **AGE:** ___ **SEX:** ☐ M ☐ F
LAST FIRST MI MM DD YYYY

HOME ADDRESS: _____
STREET CITY STATE ZIP

PHONE #: HOME (____) ____-_____ WORK (____) ____-_____ CELL (____) ____-_____

E-MAIL: _____

PRIMARY CARE DOCTOR: _____ PHONE #: (___) ____-_____ LAST SEEN: _____

PHARMACY: _____ LOCATION _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: (____) ____-_____
IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
☐ YES ☐ IF YES, NAME: _____ RELATIONSHIP _____ PHONE #: (____) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ PHONE #: (____) ____-_____
STREET CITY STATE ZIP

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ PHONE #: (____) ____-_____
STREET CITY STATE ZIP

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ POLICY # _____ GROUP # _____

ALLERGIES

☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE
☐ MEDICATIONS _____ ☐ ANESTHESIA _____
☐OTHER_____ ☐ NONE KNOWN

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER AND HERBAL SUPPLEMENTS):

_____ _____ _____
_____ _____ _____
_____ _____ _____

PATIENT NAME: _____

MEDICAL HISTORY

PLEASE CHECK THE BOX IF YOU CURRENTLY OR IN THE PAST HAVE HAD THE FOLLOWING SYMPTOMS:

ARTHRITIS:	☐ RHEUMATOID ☐ OSTEO ☐ GOUT ☐ OTHER
EENT:	☐ TONSILLITIS ☐ GLAUCOMA ☐ CATARACTS ☐ EYE /VISION DIS. ☐ HEADACHES ☐ MIGRAINES ☐ HEARING DEFICIT
GASTROINTESTINAL:	☐ ULCERS ☐ REFLUX ☐ HERNIA ☐ BOWEL DIS. ☐ IRRITABLE BOWEL SYN. ☐ HEMORRHOIDS ☐ GI BLEEDING
GENITO-URINARY:	☐ KIDNEY OR BLADDER INFECTIONS ☐ KIDNEY STONES ☐ PROSTATE DISORDER ☐ STD
MAJOR ILLNESSES:	☐ DIABETES TYPE I /TYPE II LAST A1C_____ ☐ HYPERCHOLESTROLEMIA ☐ HYPERTENSION ☐ CHEST PAIN ☐ MI ☐ CANCER ☐ MITRAL VALVE PROLAPSE ☐ HEART MURMUR ☐ ARRHYTHMIA ☐ STROKE ☐ CHF ☐ PACEMAKER ☐ HEART DISEASE
PSYCHOLOGICAL:	☐ ANXIETY ☐ DEPRESSION ☐ PSYCHIATRIC CONDITION ☐ DRUG OR ALCOHOL DEPENDENCY
RESPIRATORY:	☐ ASTHMA ☐ TUBERCULOSIS ☐ EMPHYSEMA ☐ SINUS PROBLEMS ☐ SHORTNESS OF BREATH ☐ COPD ☐ LUNG DISEASE
SKIN DISORDERS:	☐ PSORIASIS ☐ SKIN CANCER
VASCULAR DISEASE/BLOOD DISORDERS:	☐ POOR CIRCULATION ☐ SICKLE CELL ☐ PERIPHERAL VASCULAR DISEASE ☐ LEG OR CALF PAIN ☐ NIGHT CRAMPS ☐ REST PAIN ☐ VEIN PROBLEMS ☐ SWELLING ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ LEG ULCERS ☐ BLOOD CLOT ☐ DVT ☐ PE ☐ ANEMIA ☐ BLEEDING OR CLOTTING DISORDERS ☐ EASY BRUISING ☐ TRANSFUSIONS
OTHER ILLNESSES:	☐ EPILEPSY OR SEIZURES ☐ THYROID DISEASE ☐ MUSCLE DISEASE ☐ HEPATITIS ☐ HIV OR AIDS ☐ LYME DISEASE ☐ OTHER: _____
OTHERS:	**ARE YOU PREGNANT?** ☐ YES ☐ NO **ARE YOU NURSING?** ☐ YES ☐ NO **HEIGHT:** _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

SURGICAL HISTORY

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

SOCIAL HISTORY

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 ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

PATIENT NAME: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

- ☐ DIABETES: TYPE 1 OR TYPE 2
- ☐ CANCER
- ☐ THYROID DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE
- ☐ CORONARY ARTERY DISEASE
- ☐ RHEUMATOID ARTHRITIS
- ☐ OTHER _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

_____

_____

_____

_____

PLEASE READ THE ACKNOWLEDGEMENT ON THE NEXT PAGE AND SIGN IT. THANK YOU.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE