DRS. COHEN & NORTON, P.A.
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PATIENT HISTORY AND MEDICAL INFORMATION

Name:_____ Date:_____

Address:_____

Date of Birth:_____/_____/_____ Age:_____ Social Security Number:_____--_____--_____

Home Phone:_(____)_____ Cell Phone:_(____)_____ Preferred (circle): home/cell

Email Address:_____

Emergency Contact Name:_____ Emergency Phone:_(____)_____

Primary Care Doctor:_____ Date last seen:_____/_____/_____

Marital Status:_____ Spouse Name & Date of Birth:_____

Primary Language: English Spanish Other:_____

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Not Specified

Race: ___White ___Black/African American ___Asian ___American Indian/Alaskan Native
___Native Hawaiian or Other Pacific Islander

Immunizations (circle): Flu Shot Pneumonia Shot Tetanus Date of last Tetanus_____

Height:_____ Weight:_____ Shoe Size:_____

1) What is the main problem with your feet ?

_____

2) When did you first notice the condition?

_____

3) Is this an injury? (circle): Yes No If yes, when did it occur?_____
   a. If yes, did it happen at work? (circle): Yes No
   b. Are you claiming Workman's Comp? (circle): Yes No

4) Check all of the following that apply:

Type of pain:

( ) Burning	( ) Dull Ache	( ) Stabbing	( ) Sharp
( ) Tingling	( ) Throbbing	( ) Numbness	( ) Shooting

When is it painful:

( ) Upon Standing	( ) Better as Activity Continues	( ) AM
( ) During Walking	( ) Worse when Standing	( ) PM
( ) After Walking	( ) With Shoes	( ) Lying in Bed
( ) During Sports	( ) Always	

5) How painful is your condition? If 0 = no pain, and 10= the worst pain you have ever experienced (circle):

1 2 3 4 5 6 7 8 9 10

6) How has this affected your daily routine and what activities does this keep you from performing?

_____

7) Have you ever had foot care before? (circle): Yes No

a. If yes, by whom and when? _____

b. Previous problem:_____

c. Previous foot surgery:_____

ALLERGIES:

( ) NONE	( ) Iodine	( ) Shellfish	( ) Adhesive Tape
( ) Latex	( ) Sulfa	( ) Aspirin	( ) Local Anesthetics
( ) Codeine	( ) Penicillin	( ) Other:_____	

MEDICATIONS:

Please list all medications that you are currently taking (prescription and over the counter).

MEDICATION AND DOSAGE (MG)	HOW OFTEN TAKEN?	HOW MUCH DO YOU TAKE?	WHAT DO YOU TAKE THIS FOR?

( ) Check if you are NOT currently taking any medications including over the counter

What Pharmacy do you use?_____

IF YOU ARE DIABETIC: Last Blood Sugar:_____ Last HbA1c test:_____

INSULIN: YES / NO

CURRENT & PAST MEDICAL HISTORY:

( ) Acid Reflux/GERD
( ) AIDS/HIV
( ) Alcoholism
( ) Arthritis
( ) Asthma
( ) Breathing Problems
( ) Cardiac Disease
( ) Congestive Heart Disease
( ) Crohn's Disease
( ) **Diabetes**
( ) Dementia/Alzheimer's Disease
( ) DVT
( ) Edema
( ) Epilepsy
( ) Gout
( ) Hepatitis
( ) Hypertension
( ) High Cholesterol
( ) Irritable Bowel Syndrome
( ) Kidney Problems
( ) Multiple Sclerosis
( ) Osteoporosis
( ) Phlebitis
( ) Pregnancy
( ) Psoriasis
( ) Psychiatric Problems
( ) PVD
( ) Raynaud's Disease
( ) Seizures
( ) Sexually Transmitted Disease
( ) Stomach Ulcer
( ) Stroke
( ) Thyroid Disease
( ) Varicose Veins
( ) NONE
( ) OTHER:_____

PREVIOUS SURGICAL HISTORY:

( ) Abdominal Surgery
( ) Amputation
( ) Ankle Surgery
( ) Appendectomy
( ) Back Surgery
( ) Bladder Suspension
( ) Breast Surgery
( ) Bunionectomy
( ) Cardiac Catheterization
( ) Carpal Tunnel
( ) Cataract
( ) C-Section
( ) Cholecystectomy/Gallbladder
( ) Cyst
( ) Ear Tubes
( ) Eye Surgery
( ) Foot Surgery
( ) Ganglion
( ) Hammertoe Surgery
( ) Heart Surgery
( ) Hip Replacement
( ) Hysterectomy
( ) Kidney Stones
( ) Kidney Surgery
( ) Knee Replacement
( ) Mastectomy
( ) Oral Surgery/Dental Proc.
( ) Organ Transplant
( ) Prostate
( ) Stents
( ) Tonsillectomy
( ) Vascular Surgery
( ) Vein Stripping
( ) Wisdom Teeth
( ) NONE
( ) OTHER:_____

IMMEDIATE FAMILY HISTORY:

Mark any conditions that your *parents, siblings,* or *children* have or have had by indicating the family member: (M) = Mother, (F) = Father, (S) = Sister, (B) = Brother, (1) = son, and (2) = Daughter.

( ) Acid Reflux/GERD
( ) AIDS/HIV
( ) Alcoholism
( ) Arthritis
( ) Asthma
( ) Breathing Problems
( ) Cancer
( ) Cardiac Disease
( ) Congestive Heart Disease
( ) Crohn's Disease
( ) Diabetes
( ) Dementia/Alzheimer's Disease
( ) DVT
( ) Edema
( ) Epilepsy
( ) Gout
( ) Hepatitis
( ) Hypertension (High Blood Pressure)
( ) Irritable Bowel Syndrome
( ) Kidney Problems
( ) Multiple Sclerosis
( ) Osteoporosis
( ) Phlebitis
( ) Psychiatric Problems
( ) PVD
( ) Raynaud's Disease
( ) Rheumatic Heart Disease
( ) Seizures
( ) Sexually Transmitted Disease
( ) Stomach Ulcer
( ) Stroke
( ) Thyroid Disease
( ) Varicose Veins
( ) NONE
( ) N/A – Adopted

SOCIAL HISTORY:
(Circle all that apply)

Marital Status: Married Single Widowed Divorced Separated

Who do you live with: Husband Wife Alone Children Parents Significant Other Assisted Living

Children: 1 2 3 4 or more_____

Employment: Employed: where_____ Unemployed Disabled Retired Student

Smoking: Never Former Light Smoker Heavy Smoker Number of packs per day_____

Caffeine use (coffee, tea, soda, etc.): 1-2 servings/day 3-5 servings/day 6-9 servings/day
Over 9 servings/day

Alcohol Use: Non-Drinker Social/Moderate Heavy Drinker Alcoholic

Pregnant: Yes No

Nursing: Yes No

REVIEW OF ALL SYSTEMS:
(Circle all that apply)

Constitutional:

( ) Chills
( ) Dizziness
( ) Fever
( ) Sweats
( ) Weight Loss Intentional
( ) Weight Loss Unintentional

Head, Ears, Nose and Throat:

( ) Difficulty Hearing
( ) Difficulty Swallowing
( ) Dry Mouth
( ) Nose Bleeds
( ) Ringing in Ears

Cardiovascular:

( ) Chest Pain/ Heart Attack
( ) Fainting Spells
( ) Heart Palpitations
( ) Leg Pain with exercise
( ) Leg/ Ankle/ Feet Swelling

Eyes:

( ) Contacts
( ) Double Vision
( ) Glasses

Endocrine:

( ) Excessive Thirst
( ) Frequent Urination
( ) Intolerance to Cold and Heat

GI:

( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Heartburn
( ) Loss of Appetite
( ) Nausea

GU:

( ) Frequent Urination
( ) Urgency of Urination
( ) Incontinence

Musculoskeletal:

( ) Back Pain
( ) Joint Pain
( ) Leg Cramps
( ) Muscle Pain
( ) Stiffness

Immunological:

( ) Arthritic Flare-Up's
( ) Recurrent Infections

Neurological:

( ) Numbness/ Tingling
( ) Seizures
( ) Tremors

Integument:

( ) Bruise Easily
( ) Dry Skin
( ) Hair Loss
( ) Hyperpigmentation
( ) Keloids – Thick Scars

Psychiatric:

( ) Anxiety
( ) Binging
( ) Depression

Lymphatic:

( ) Bloating
( ) Swelling
( ) Pitting edema

Respiratory:

( ) Difficulty Breathing
( ) Shortness of breath
( ) Sleep Apnea
( ) TB Exposure

( ) PATIENT DENIES ANY OF THE ABOVE

HIPAA COMPLIANCE:

As required by Federal Law, we will not share your medical information without your permission.

With whom do you allow us to share your health information if you are unavailable?

Name:_____ Relationship:_____

How may we leave lab, testing results, and appointment reminders:

Home Answering Machine	Yes	/ No
Voicemail	Yes	/ No
E-mail	Yes	/ No

Text Yes / No

FINANCIAL AGREEMENT:

INSURANCE: It is the patient's responsibility to provide our office with your current insurance card and inform us of any changes in the insurance. Without your correct information, you will be responsible for your bill.

COPAYS, CO-INSURANCE & NON-COVERED SERVICES: It is office policy that these are paid at the time of service. We accept cash, check, or credit card payments. Copays, co-insurance and deductibles cannot be waived by our practice, as they are requirements placed on you by your insurance carrier.

MISSED APPOINTMENT FEE: A $25.00 charge will be added to your account for a missed appointment. (A no-fee first courtesy will be issued for your first missed appointment, but fees will be charged for any missed appointments thereafter.)

PAST DUE BALANCE: You will be asked to pay any past due balances when making appointment or before seeing a physician. If your balance is especially high, you can set up a payment plan with the Billing Coordinator.

RETURNED CHECKS: A $25.00 charge will be added to your account for any check returned by your bank.

FINANCE CHARGE: If your bill is over 90 days old, we will impose a finance charge of $15.00. We will continue to impose $15.00 monthly fees until your account is paid in full. These fees will help to offset the excessive monthly cost involved in continuing to send overdue bills.

COLLECTION FEE: If after several months a balance remains unpaid, we will send your account to our collection attorney. We will impose a collections fee of one third of the outstanding bill to cover the fee charged to us by the collection agency.

MEDICAL SAMPLES DISCLOSURE:

☐ By checking this box, I acknowledge that I may receive samples of medicines which are being dispensed in a non-child-resistant container. I accept full responsibility for keeping the medication out of the reach of children.

I certify that the information given above true and correct. I understand that providing incorrect information can be dangerous to my health. I acknowledge that it is my responsibility to notify your office of any changes to the above information.

PATIENT OR GUARDIAN SIGNATURE:_____

DATE:_____

DRS. COHEN & NORTON, P.A.

Podiatric Medicine and Foot Surgery

Phillip M. Cohen, D.P.M.

Nancy S. Norton, D.P.M.

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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 understood the Notice.

Patient Name (please print) Date

Parent of Authorized Representative (if applicable)

Signature