LINCOLN
foot & ankle center

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ _____ ___
LAST FIRST MI

HOW SHOULD WE ADDRESS YOU? _____ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

HT : WT: SHOE SIZE:

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

WHO REFERRED YOU TO US?

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE #: (____) ____-_____

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

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

NAME(S) _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

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

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

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 A DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

FAMILY HISTORY

DO ANY 1ST DEGREE RELATIVES HAVE A HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES TO: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NO ALLERGIES THAT I KNOW OF

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OPEN SORES	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		RHEUMATIC FEVER	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		SICKLE CELL DISEASE	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SKIN DISORDER	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SLEEP APNEA	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		STOMACH ULCERS	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STROKE	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
CANCER	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
DIABETES	Y	N		***OTHER CONDITIONS:***						

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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.

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ _____

SIGNATURE DATE