associates in podiatry

LYNNE J. HAUBELT, D.P.M.
SHANNON L. MCFEATERS, D.P.M.
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PATIENT INFORMATION (Please print clearly)
Present all insurance cards to the receptionist

Date_____

Name (Last)_____(First)_____(MI)_____
Address (Street)_____(City)_____(State)_____(Zip)_____
Phone (Home)_____(Mobile)_____(Work)_____
EMAIL_____Preferred phone ☐ Home ☐ Mobile ☐ Work
If we need to contact you, are we permitted to leave a message on your voicemail? ☐ YES ☐ NO
Birthdate_____/_____/_____ Age_____ Social Security#_____-_____-_____ Gender ☐M ☐F ☐other
Patient's Occupation_____Patient's Employer_____
Employer Address_____Phone_____
Marital Status S M D W Spouse's Name_____Birthdate_____/_____/_____

Family Doctor_____Phone_____
Address_____Last seen___/___/___
Diabetic Doctor (if applicable)_____Phone_____
Address_____ Last seen___/___/___
Pharmacy_____Location_____Phone_____
Emergency Contact/ Relationship_____Phone_____
How were your referred to our office?_____

Insurance Company_____Secondary_____
Patient is ☐Subscriber ☐Spouse ☐Dependent ☐Other_____ **If Subscriber, skip to next section**
Policy Holder Name_____Policy Holder Phone_____
Policy Holder Address_____Policy Holder Birthdate_____/_____/_____

Disclosure of Health Information: I wish to allow disclosure of my health information to the following family members, friends or individuals. I understand that I may change this list at any time by informing this office in writing of the change.

Name	Relationship to patient	Phone number

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge, and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to having photographs taken, which will be used for medical treatment at the discretion of the doctor.

Patient/Parent/Guardian Signature_____Date_____

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MEDICAL HISTORY (Please print clearly)

Complete all sections

Date_____

Name (Last)_____(First)_____(MI)_____

Birthdate_____/_____/_____ Age_____ Height_____ Weight_____ Shoe Size_____

Reason for Visit (Foot/ Ankle Complaint)_____

Past Medical History (Circle all you have currently or had in the past)

Alcoholism	Crohn's/ IBS	Kidney Disease	Skin Condition
AIDS or HIV	Diabetes Mellitus	Liver Disease	Stomach Ulcer/Reflux
Anemia/ Sickle Cell	Drug Abuse	Lung Disease	Stroke
Arthritis (RA or OA)	Fibromyalgia	Muscular Disorder	Thyroid Disease
Asthma/ COPD	Gout	Mental Disorder	Venereal Disease
Autoimmune Disease	Heart Disease	Nerve Disorder	Other_____
Bleeding Disorder	Hepatitis	Osteoporosis	_____
Cancer_____	High Blood Pressure	Poor Circulation	_____

Medications (Provide a list of all medicines you take, or complete the patient medication form) ☐ **Mark here if none taken**

Allergies (Check all that apply)

☐Penicillin ☐Sulfa ☐Iodine
☐Codeine ☐Aspirin ☐Cortisone
☐Anesthetics ☐Latex ☐ Adhesive Tape
☐No Known Allergies ☐Other_____

Social History

Do you smoke _____ If no did you ever smoke_____
How much_____How long_____
Do you drink alcohol_____How much/ often_____
Do you or have you used recreational/ street drugs_____

Surgical History and Hospitalizations (List all you have had in the past 5 years)

_____
_____
_____

Family History (Write **M** for mother, **F** for Father, **S** for Sibling or **C** for Child if any of the following apply)

Anemia_____Anesthetic Reaction_____Arthritis_____ Bleeding Disorder_____Cancer_____
Diabetes_____Heart Disease_____High Blood Pressure_____Stroke_____Varicose Veins_____
Bone Disease_____Kidney Disease_____Liver Disease_____Lung Disease_____Muscle Disease_____
Nerve Disease_____Psychiatric Disorder_____Other_____Family History Unknown_____

Review of Systems (Circle all that you are currently experiencing)

Women: Pregnant Yes/ No Breast Feeding Yes/ No Chance of Pregnancy Yes/ No

General: fever, chills, weight loss/gain, fatigue **Head:** headache, concussion, dizziness, memory loss, seizure, epilepsy **Eyes:** glasses, contacts, blurred vision, blindness, cataracts, glaucoma, macular degeneration **Ears:** hearing loss, tinnitus, earaches **Nose:** blockage, bleeding, sinusitis, drainage **Throat:** sore throat, speech loss, difficulty swallowing **CVS:** A-fib, heart attack, defibrillator, chest pain, murmur, SOB, pacemaker, valvular disease, high cholesterol **Circulation:** leg cramps, blood clots, swelling, Raynaud's **Respiratory:** bronchitis, TB, pneumonia, wheezing, cough **Skin:** rash, wound, cyst, itching, psoriasis **Musculoskeletal:** back pain, joint pain, muscle pain, stiffness **GI:** nausea/ vomiting, diarrhea, constipation, stomach pain **GU:** UTI, kidney stones, dialysis **Psychological:** depression, anxiety, ADHD, Autism

Patient/Parent/Guardian Signature_____Date_____