

Practice: **Dr Steven Lashley DPM**



Date: _____

Name: _____

DOB: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

Spouse/Partner Name: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Northern Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____

Phone #: _____

How did you find out about our practice? Physician _____ Internet

Telephone book Family member _____

Friend _____ Other: _____

What is the reason for your visit today?

How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective?

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10.

The pain quality is: burning constant dull sharp shooting throbbing tingling

Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above

Signature: _____ Date: _____

Practice:

Today's Date:

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American

White Native Hawaiian or other Pacific Islander Declined to specify

Preferred Language: _____ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City, State, Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

~~**Privacy Information Preferences**~~

~~Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No~~

~~Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No~~

~~Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No~~

~~If yes, please provide your e-mail address: _____~~

~~Who can we leave messages with? Wife Husband Daughter Son Other: _____~~

~~Name(s): _____~~

Smoking Status

Current Every Day Smoker, Current Status Unknown

Current Some Day Heavy Tobacco Unknown If Ever

Former Never Light Tobacco decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Name / Dose: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

Have you fallen in the last 12 months? Yes No **Were you injured from the fall?** Yes No

Advanced Directives: Living Will DNR Durable Power of Attorney Surrogate Appointed None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ **Date:** _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues	
<input type="checkbox"/> Liver	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Blood clot	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type 1, type 2)			
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> other (specify) _____	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA		

Are you pregnant? Yes No **Are you nursing?** Yes No Skin disorders Stroke

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

Review of Systems (Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet	
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE	
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency		
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE	
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> ulcers	<input type="checkbox"/> constipation
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> NONE	
Integumentary	<input type="checkbox"/> athletes foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin	<input type="checkbox"/> NONE
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders	<input type="checkbox"/> NONE
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches	
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE	
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain	
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis	<input type="checkbox"/> NONE
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring	
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE	

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Patient Signature: _____

Date: _____