PATIENT LABEL

New Patient Questionnaire

NAME: ______________________________ DOB: __________ **AGE**:________

FIRST MI LAST

SS#: _______ - _____ - _______ **MARITAL STATUS:** single married separated divorced widowed
(PLEASE CIRCLE)

ADDRESS: ____
STREET CITY STATE ZIP

HOME PHONE: (_____) ______ - _______ WORK PHONE: (_____) ______ - _______ CELL PHONE: (_____)______ - _______

PATIENT'S EMPLOYER:______________________ **OCCUPATION:**______________

E-MAIL ADDRESS: ______________________ **Can we use?: YES NO**
(We will not give your e-mail address out to anyone, for any reason. We will only send important information to you)

EMERGENCY CONTACT: __________________ **RELATIONSHIP:** __________________

PHONE NUMBER: (____) ______ - _______ **Referral Source:**__________________

INSURANCE INFORMATION

(If your condition is due to an accident or injury from work, autos, or third party, please see Staff.)

PRIMARY INSURANCE: __________________ **EFFECTIVE DATE:** __________
POLICY HOLDER'S NAME:__________________ **DOB:**__________ **SS#**__________

SECONDARY INSURANCE: __________________ **EFFECTIVE DATE:** __________
POLICY HOLDER'S NAME:__________________ **DOB:**__________ **SS#**__________

REVIEW OF SYSTEMS

HEIGHT: _________ **WEIGHT:** ________ **SHOE SIZE:** _________

Family Physician and phone: __________________ **Date last seen:** __________

Reason for your appointment with us: __________________

How long have you had this problem? __________________

Have you ever seen a Podiatrist? (If so, by whom and for what type of treatment)**:** __________________

Have you ever had a problem with Anesthesia? ( ) Yes ( ) No If yes, please explain.: __________________

ALLERGIES: __________________ **MEDICATIONS:** __________________

Please check any of the following that pertains to you.

Constitutional:
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fatigue
- ❑ Night sweats
- ❑ Weakness
- ❑ Chills
- ❑ Headaches

Respiratory:
- ❑ Difficulty breathing
- ❑ Cough
- ❑ History of Pneumonia
- ❑ Smoker Packs/day: ________
- ❑ TB exposure
- ❑ Lung or breathing problems

Social:
- ❑ Use of alcohol
  - ❑ rarely
  - ❑ moderately
  - ❑ daily
- ❑ Use of illicit drugs
  Type/Frequency:
  ____

Endocrine:
- ❑ Diabetes Type: ________
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Eat a lot
- ❑ Drink a lot
- ❑ Urinate a lot

Ears:
- ❑ Hearing loss
- ❑ Ringing in the ears
- ❑ Dizziness

Eyes:
- ❑ Glasses
- ❑ Blurred vision
- ❑ Pain/Dry/Red/Watery

Nose:
- ❑ Congestion
- ❑ Sinus problems
- ❑ Bleeding
- ❑ Sneezing

Throat:
- ❑ Pain
- ❑ Difficulty swallowing
- ❑ Hoarseness

Cardiac:
- ❑ Chest pain
- ❑ Murmurs
- ❑ Peripheral Edema
- ❑ Claudicating
- ❑ Bleeding problems
- ❑ Blood transfusion
- ❑ Heart problems Type: _______________
- ❑ Hypertension
- ❑ Phlebitis
- ❑ Poor circulation
- ❑ Stroke Type: _____________

Gastrointestinal:
- ❑ Indigestion
- ❑ Reflux
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Abdominal pain
- ❑ Heartburn
- ❑ Liver problems
- ❑ Stomach ulcer
- ❑ Hepatitis exposure

Musculoskeletal:
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Swelling in feet or legs
- ❑ Trauma
- ❑ Trauma to feet or legs
- ❑ Muscle aches
- ❑ Muscle weakness
- ❑ Tremors
- ❑ Back pain
- ❑ Cramping of feet or legs
- ❑ Gout

Genitourinary:
- ❑ Frequent urination
- ❑ Urgency of urination
- ❑ Blood in the urine
- ❑ Kidney problems

Blood/Lymph:
- ❑ Anemia
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Swollen glands

Immune:
- ❑ Cancer
- ❑ Infectious/contagious disease
- ❑ Poor healing
- ❑ HIV/AIDS

Neuro/Psych:
- ❑ Seizures
- ❑ Passing out
- ❑ Coordination problems
- ❑ Depression
- ❑ Anxiety
- ❑ Insomnia

Please list ALL surgeries:

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

PATIENT SOCIAL HISTORY AND FAMILY MEDICAL HISTORY
SOCIAL HISTORY

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed Preferred Language: ___________________

Race ❑ Caucasian ❑ Hispanic ❑ Black ❑ Other Ethnic Group: ___________________

Excessive exposure at home or work to
❑ Fumes ❑ Dust ❑ Solvents ❑ Air-borne particles

What Style shoes do you wear at work? __________________________ Home:_______________________

How much standing/walking do you do at work? _________________________

FAMILY MEDICAL HISTORY

FATHER: ❑ Stroke ❑ Diabetes ❑ Heart Problems ☐ Kidney Problems ❑ Poor Circulation ❑ Gout

Other____

MOTHER: ❑ Stroke ❑ Diabetes ❑ Heart Problems ☐ Kidney Problems ❑ Poor Circulation ❑ Gout

Other____

SIBLINGS: ❑ Stroke ❑ Diabetes ❑ Heart Problems ☐ Kidney Problems ❑ Poor Circulation ❑ Gout

Other____

CHILDREN: ❑ Stroke ❑ Diabetes ❑ Heart Problems ☐ Kidney Problems ❑ Poor Circulation ❑ Gout

Other____

HEALTH INFORMATION PRIVACY PRACTICES ACT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNATURE: ____ **DATE:** ____ - ____ - ____

AUTHORIZATION

I understand that there may be times when the clinic may need to contact me.

I give the. staff permission to contact me:

❑ At home ❑ Cell phone ❑ at work

I give the staff permission to leave messages on:

❑ my home answering machine ❑ My work answering machine ❑ My cell phone voicemail

I give Baker Foot Solutions Corp. staff permission to leave messages with:

Name: _________________________ **Relationship:**______________ **Telephone #** __________________

Name: _________________________ **Relationship:**______________ **Telephone #** __________________

Please list the names of any people and their relationship to you if you wish us to release confidential information to them:

Name: _________________________ **Relationship:**______________ **Telephone #** __________________

Name: ______________________ Relationship:_____________ Telephone # ________________

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MINOR CHILD CONSENT

I give consent for Dr. Michael Baker, Dr. Jason Gray, and Dr. Gregory Boake, Jessica Taulman-Young and Tiffany Koch to render medical care to my child. I also give consent for my child to be seen and/or medically treated without the legal guardian being present at the time of service.

PATIENT: ____________________________ **DATE OF BIRTH: ___ - ___ - ___**
NAME OF MINOR CHILD

LEGAL GUARDIAN: __________________________ **RELATIONSHIP: ___________________**

SS#_______________________________ **DOB______________________________**

HOME PHONE: (___) _____ - _______ WORK PHONE: (___) _____ - _______ CELL PHONE: (___) _____ - ______

NON-CUSTODIAL PARENT: __________________________ **RELATIONSHIP: ___________________**

HOME PHONE: (___) _____ - _______ WORK PHONE: (___) _____ - _______ CELL PHONE: (___) _____ - ______

ADDRESS: ____
STREET CITY STATE ZIP

SIGNATURE: ___________________________________ **DATE: ___ - ___ - ___**
LEGAL GUARDIAN

WITNESS: ______________________________________ **DATE: ___ - ___ - ___**

*** I __________________________, give permission to contact or release medical
Custodial parent
Information to ______________________________.
Non-custodial parent

☺ **THANK YOU! THIS LITTLE EXTRA EFFORT ON YOUR PART HELPS US HELP YOU!** ☺