Patient Registration and Health History

Welcome to Colorado Foot and Ankle. We are pleased that you have chosen us as your foot and ankle provider.

COLORADO FOOT AND ANKLE

I. Patient Information

Date _____

Patient _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell _____ Work _____
Patient SS# _____
Birthday _____ Age _____ Sex M or F

Whom may we thank for referring you? _____
Would you like a summary of today's visit? Yes or No
Email Address: _____

II. Emergency Contact

Name _____ Relationship _____
Home Phone _____ Cell Phone _____

III. Insurance

Who is responsible for this account? _____ Relationship to Patient _____
Primary Insurance _____
ID # _____ Group# _____
Subscriber Name _____
Birthdate _____ SS# _____

Secondary Insurance _____
ID # _____ Group# _____
Subscriber Name _____
Birthdate _____ SS# _____

IV. Basic Health Information

Primary Care Provider _____ Date Last Seen _____
Preferred Pharmacy Name and Location _____
*Preferred Language _____
*Please Select Your Race: American Indian / Alaskan Native / Asian / African American / Caucasian / Pacific Islander/ Other/ Declined
*Please Select Your Ethnicity: Hispanic / Non-Hispanic / Declined

***Requirement of our Government's Health Information Technology for Economic and Clinical Health Act (HITECH)**

V. Podiatric History (**Are you currently or have you been treated in the past for any of the following conditions? Please Circle.**)

Ankle Pain	Athlete's Foot	Bunions	Corns & Calluses	Cramps or Numbness
Flat Feet	Foot or Leg Cramps	Heel Pain	Ingrown Toenails	Plantar Warts

What is the reason for your visit today?_____

_____

_____

Have you been to a Podiatrist before? If yes, please list_____Last Visit_____

VI. Medical History (**Are you currently or have you been treated in the past for any of the following conditions? Please Circle.**)

Alcohol chemical dependency	COPD	Heart disease	Liver disease
Anemia	Depression	Heart murmur	Menopause
Arthritis (type): _____	Diabetes- Type I or Type II	Hepatitis (type): _____	Migraines
Asthma	Emphysema/Bronchitis	High cholesterol	Osteoporosis
Bipolar disorder	Epilepsy/ Seizure Disorder	HIV Status: + - unknown	Prostate problems
Bleeding disorders	Fibromyalgia	HTN/ High blood pressure	Rheumatic fever
Blood clots/ DVT/PE	GERD/ Reflux	Hyperthyroidism	Sleep apnea/ difficulties
Cancer (type):	Glaucoma	Hypothyroidism	Stroke/TIA
Cardiac arrhythmia	Gout	Hypotension	Stomach ulcers
Crohn's/ Ulcerative Colitis	Heart attack- MI	Kidney disease	Tuberculosis

Others: _____

VII. Surgeries & Hospitalizations (**List all procedures, locations and any complications.**)

_____

_____

_____

VIII. Medications (**List all prescription or over-the-counter that you are currently on. Please include dosage and frequency.**)

_____

_____

_____

_____

IX. Allergies (**List the medication and the reaction that it has caused.**)

_____

_____

X. Social History

Marital Status: ___Single ___ Married ___Widowed ___Divorced

Employed? ___yes ___no Type of work? _____

Smoking Status: ___never ____current smoker ___former smoker ___social smoker

Smoking Amount: ½ pack/day 1 pack/ day 2 pack/ day 3 pack/ day 4 or more pack/ day How Long?_____

Tobacco Exposure at your home? ___yes ___no Smoker in home smokes: ___ inside ___outside

Do you drink alcohol? ___yes ___ no ___Rare ___Occasional ___Social ___Daily ___Former ___Recovering Alcoholic

Drinking amount: 1-2/ day 3-4/ day 5-6/ day >7/day 1-2/ week 3-4/ week 5-6/ week >7/ week

Do you use recreational drugs? ___ yes ___ no How often? _____

Do you exercise routinely? ___ yes ___ no What activities? _____

XI. Family History (**Do you have any family members begin treated for the following medical condition? If so, who and for what?**)

Anemia	___yes	___no	Who?
Arthritis	___yes	___no	Who?
Asthma	___yes	___no	Who?
Cancer	___yes	___no	Who?
Diabetes	___yes	___no	Who?
Heart Disease	___yes	___no	Who?
High Cholesterol	___yes	___no	Who?
Hypertension	___yes	___no	Who?
Kidney Disease	___yes	___no	Who?
Neurologic	___yes	___no	Who?
Stroke/ TIA	___yes	___no	Who?
Thyroid Disease	___yes	___no	Who?
Vascular Disease	___yes	___no	Who?

XII. Review of Systems (Please circle any of the following symptoms that you are currently experiencing.)

Nausea	Vomiting	Fevers	Chills	Night Sweats
Dizziness	Light Headiness	Headaches	Hearing loss	Ringing in ears
Blurred Vision	Dry eyes	Itchy eyes	Sinus congestion	Sneezing
Cough	Dry Mouth	Sore throat	Difficulty swallowing	Shortness of breath
Wheezing	Chest Pain	Heart Palpitations	Heartburn	Constipation
Diarrhea	Bloody stool	Abdominal Pain	Incontinence	Frequent Urination
Leg swelling	Calf or leg cramps	Foot Cramps	Muscle Pain	Back Pain
Joint pain/ swelling/ stiffness (list locations) _____			Chronic Pain Affecting Work or Home Life	
Weakness	Abnormal Sensation	Numbness	Tingling	Burning
Tremors	Memory loss	Speech difficulties	Confusion	Disorientation
Skin Ulcers	Rashes	Skin Sores	Warts	Calluses
Dry skin	Changes in toenails	Varicose veins	Hair loss	Excessive sweating
Increased thirst	Increased hunger	Weight gain	Weight loss	Heat Intolerance
Cold Intolerance	Depression	Irritability	Mood swings	Sleep problems
Bruises easily	Bleeding issues	Swollen lymph nodes	Recurring infections	Chronic Fatigue

XIII. Consent to Treat

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Colorado Prescription Drug Monitoring Program

IF YOU RECEIVE A PRESCRIPTION FOR"CONTROLLED" (SCHEDULE II THROUGH V) DRUG, YOUR IDENTIFYING PRESCRIPTION INFORMATION WILL BE ENTERED INTO COLORADO'S ELECTRONIC PRESCRIPTION DRUG MONITORING DATABASE (PDMP) WHEN THIS DRUG IS DISPENSED TO YOU. YOUR PRESCRIPTION INFORMATION IN THE DATABASE IS A PROTECTED HEALTH RECORD AND CANNOT BE ACCESSED BY NON-CAREGIVERS EXCEPT AS PART OF AN AUTHORIZED INVESTIGATION.

YOU HAVE A RIGHT TO ACCESS YOUR INFORMATION IN THE PDMP THROUGH THE COLORADO BOARD OF PHARMACY. YOU MAY SEEK CORRECTIONS TO THE INFORMATION AS YOU WOULD YOUR OTHER MEDICAL RECORDS.

I request the following restrictions to the use or disclosure of my health information:

____Accepted _____ Denied

_____ _____/_____/_____

Patient/Parent or Guardian Signature Date

XIV. Physical Examination (For Office Use Only)

Vitals: Pulse: _____ BP: _____ Right/ Left Height: _____ Weight: _____

Chief Complaint:

HPI: