



### 4 *PODIATRIC HISTORY*

What is the chief complaint for which you came to be treated: (Include foot, ankle, knee, thigh, and hip complaints).

Have you ever seen a Podiatrist before: [ ] Yes [ ] No      If yes:

Name of Podiatrist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

### 5 *SOCIAL HISTORY*

|               |         |        |                    |         |        |
|---------------|---------|--------|--------------------|---------|--------|
| Cigarettes    | [ ] Yes | [ ] No | Tea                | [ ] Yes | [ ] No |
| Other Tobacco | [ ] Yes | [ ] No | Cola Drinks        | [ ] Yes | [ ] No |
| Alcohol       | [ ] Yes | [ ] No | Recreational Drugs | [ ] Yes | [ ] No |
| Coffee        | [ ] Yes | [ ] No |                    |         |        |

### 6 *FAMILY HISTORY*

Have any of your relatives ever had any of the following: If yes, who?

|                     |         |        |              |         |        |
|---------------------|---------|--------|--------------|---------|--------|
| Diabetes            | [ ] Yes | [ ] No | Tuberculosis | [ ] Yes | [ ] No |
| Heart Trouble       | [ ] Yes | [ ] No | Stroke       | [ ] Yes | [ ] No |
| High Blood Pressure | [ ] Yes | [ ] No | Epilepsy     | [ ] Yes | [ ] No |
| Cancer              | [ ] Yes | [ ] No | Arthritis    | [ ] Yes | [ ] No |

### 7 *MEDICATIONS*

Include prescription, over-the-counter medications and vitamins: (If you have a list, we can photo copy it)

Pharmacy Name(s): \_\_\_\_\_

Pharmacy Phone(s): \_\_\_\_\_

Do you take oral contraceptives? [ ] Yes [ ] No

### 8 *ALLERGIES*

Allergies

Reactions

## 9 MEDICAL HISTORY/ILLNESSES

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Shoe Size:** \_\_\_\_\_

- |                      |                |                           |                |                          |                |
|----------------------|----------------|---------------------------|----------------|--------------------------|----------------|
| AIDS/HIV             | [ ] Yes [ ] No | Glaucoma Eye Disease      | [ ] Yes [ ] No | Radiation Treatment      | [ ] Yes [ ] No |
| Anemia               | [ ] Yes [ ] No | Gout                      | [ ] Yes [ ] No | Rash/Skin Disorders      | [ ] Yes [ ] No |
| Angina               | [ ] Yes [ ] No | Hardening of the Arteries | [ ] Yes [ ] No | Respiratory Disease      | [ ] Yes [ ] No |
| Arthritis            | [ ] Yes [ ] No | Headaches                 | [ ] Yes [ ] No | Rheumatic Fever          | [ ] Yes [ ] No |
| Valve/Joint          | [ ] Yes [ ] No | Heart Disease             | [ ] Yes [ ] No | Scarlet Fever            | [ ] Yes [ ] No |
| Asthma               | [ ] Yes [ ] No | Hemophilia                | [ ] Yes [ ] No | Shortness of Breath      | [ ] Yes [ ] No |
| Back Problems        | [ ] Yes [ ] No | Hepatitis                 | [ ] Yes [ ] No | Sinus Problems           | [ ] Yes [ ] No |
| Bleeding Disorders   | [ ] Yes [ ] No | High Blood Pressure       | [ ] Yes [ ] No | Stroke                   | [ ] Yes [ ] No |
| Cancer               | [ ] Yes [ ] No | Immunodeficiency          | [ ] Yes [ ] No | Swollen Neck Glands      | [ ] Yes [ ] No |
| Chemical Dependency  | [ ] Yes [ ] No | Jaundice                  | [ ] Yes [ ] No | Thyroid Disease          | [ ] Yes [ ] No |
| Chest Pain           | [ ] Yes [ ] No | Kidney Problems           | [ ] Yes [ ] No | Tuberculosis             | [ ] Yes [ ] No |
| Circulatory Problems | [ ] Yes [ ] No | Liver Disease             | [ ] Yes [ ] No | Stomach/GI Ulcers/Reflux | [ ] Yes [ ] No |
| Depression           | [ ] Yes [ ] No | Low Blood Pressure        | [ ] Yes [ ] No | Varicose Veins           | [ ] Yes [ ] No |
| Diabetes             | [ ] Yes [ ] No | Neurological Disease      | [ ] Yes [ ] No | Venereal Disease         | [ ] Yes [ ] No |
| Epilepsy             | [ ] Yes [ ] No | Nosebleeds                | [ ] Yes [ ] No |                          |                |
| Foot or Leg Cramps   | [ ] Yes [ ] No | Phlebitis                 | [ ] Yes [ ] No |                          |                |
| Feet/Ankles Swelling | [ ] Yes [ ] No | Psychiatric Care          | [ ] Yes [ ] No |                          |                |

**Are you or could you be pregnant?** [ ] Yes [ ] No

**List surgeries you have had:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 10 CONSENT

**I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
*(TO BE SIGNED BY ALL PATIENTS)*

I authorize Advanced Foot Care Center, LLC to release information as needed, from my records for filing my insurance benefits. I further authorize payment directly to the treating physician for benefits due to me under my insurance contract, but not to exceed fees charged. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that the policy of the physician of Advanced Foot Care Center, LLC is that the parent who requests the treatment of a minor is responsible for all the fees for the services rendered. A copy of this authorization is as valid as the original (until revoked in writing) and is kept on file with my records.

Is this medical condition due to an accident of any kind?       Yes     No

If yes:                      Is it work related:                       Yes     No  
Auto related:                       Yes     No  
Injured at home:                       Yes     No  
Date of Injury: \_\_\_\_\_ Other: \_\_\_\_\_

Is the patient presently employed?                       Yes     No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE SECONDARY PAYER**  
*(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)*

1.      Is the patient a Veteran?                       Yes     No
2.      Do you have a Federal Black Lung Card?  Yes     No

**MEDIGAP AUTHORIZATION**

I hereby consent and give my permission to Dr. McCalla and/or Dr. Brodine (and the doctor's assistants or designated assistants) to administer and perform such procedures upon me as the doctor deems necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to the treating physician for services furnished to me by that physician. I authorize information to be released to the Centers for Medicare and Medicaid Services and its agents to determine benefits or the benefits payable for related services. If "other health insurance" is indicated, my signature authorizes releasing information to that insurer or agency. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_