NEW PATIENT QUESTIONAIRE

NAME (FIRST,MIDDLE,LAST)_____BIRTHDATE_____

MAILING ADDRESS_____

CELL _____ HOME _____ PREFFERED CONTACT METHOD_____

SSN#_____ GENDER_____ RACE_____ OCCUPATION _____

EMERGENCY CONTACT (NAME, PHONE #,RELATIONSHIP) _____

*LIST ANYONE THAT WE MAY DISCLOSE INFORMATION REGARDING YOUR HEALTHCARE. IF NO ONE IS LISTED WE WILL DISCLOSE INFORMATION ONLY TO YOU. _____

***YOU MUST PRESENT YOUR INSURANCE CARDS FOR COPYING. IF NO CARDS ARE PRESENTED AND SERVICES ARE RENDERED, ALL CHARGES WILL BE APPLIED AS A SELF-PAY PATIENT.**

FAMILY PHYSICIAN_____ OFFICE PHONE_____

PHARMACY_____ ADDRESS (STREET & CITY) _____

HOW DID YOU FIND BFFSP? _____

IF NECESSARY, MAY WE OBTAIN RECORDS, INCLUDING LABS, IMAGES AND NOTES FROM OTHER DOCTORS YOU HAVE SEEN? THIS WILL ONLY BE NECESSARY TO PROVIDE YOU WITH THE BEST CARE. **Y** **N**

IF YOU WOULD LIKE ACCESS TO YOUR PATIENT PORTAL, PLEASE PROVIDE AN EMAIL ADDRESS. IF PROVIDED, IT WILL BE USED FOR THIS PURPOSE ONLY.

EMAIL_____

MEDICAL INFORMATION:

PLEASE DESCRIBE THE FOOT PROBLEM YOU ARE EXPERIENCING:

_____

HEIGHT_____WEIGHT_____ GLUCOSE/HA1C_____/_____SHOE SIZE_____

ALLERGIES_____

MEDICATIONS (RX AND NONRX) _____

_____

_____

<u>PAST MEDICAL HISTORY</u> (**DISEASES, ILLNESSES, INJURIES** *DIAGNOSED BY A DOCTOR*) **. CIRCLE ANY THAT APPLY OR APPLIED TO YOU,** *PAST OR PRESENTLY.*

HIGH BLOOD PRESSURE(HTN) DIABETES I/II HIGH CHOLESTEROL/BLOOD FATS STROKE/CVA/TIA MI/HEART ATTACK PAD/PVD KIDNEY DISEASE/DIALYSIS LIVER DISEASE BLOOD CLOT ASTHMA COPD AUTOIMMUNE DISORDER(RA,LUPUS) HIV HEP-C GOUT SCIATICA NEUROPATHY HEARING LOSS PSORIASIS MENTAL ILLNESS DEMENTIA PARKINSON'S ALZHEIMERS PARALYTIC CONDITION CROHN'S HEART DISEASE MULTIPLE SCLEROSIS CANCER (TYPE) _____

OTHER_____

PAST SURGICAL HISTORY. ***ALL SURGERIES*** YOU HAVE UNDERGONE IN YOUR LIFETIME. CIRCLE ANY.

PACEMAKER/DEFIB. STENT BYPASS ORGAN TRANSPLANT BACK SURGERY CHEMO/RADIATION HYSTERECTOMY FRACTURE/BONE BREAK GALLBLADDER REMOVED HIP OR KNEE REPLACEMENT

OTHER_____

SOCIAL HISTORY

DO OR DID YOU SMOKE CIGARETTES OR CIGARS? Y N IF YOU QUIT, HOW LONG AGO?_____

DO YOU DRINK ALCOHOL? Y N HOW MANY GLASSES/CANS?_____ HOW OFTEN?_____

DO YOU DO ANY OTHER DRUGS, IF SO LIST THEM_____

WHO DO YOU LIVE WITH OR WHO LIVES WITH YOU?_____

BY SIGNING BELOW, I GIVE MY PERMISSION FOR DR.BAKER AND ASSOCIATES TO PERFORM THERAPEUTIC, DIAGNOSTIC AND/OR OPERATIVE PROCEDURES NECESSARY TO DIAGNOSE AND TREAT MY FEET AND ANKLES.

I CONSENT TO TEXT OR CALL APPT.REMINDERS.

PATIENT/LEGAL GUARDIAN SIGNATURE_____DATE_____