## **FAMILY FOOT CENTER**

Cookeville, Crossville, Livingston, Smithville

## 2024 Updated Information

Although podiatry personnel primarily treat the area in and around your foot, your foot is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the podiatric care you will receive.

Thank you for answering the following questions.

Patient Information:

Address:    City   State   Zip	Patient Name: Dr./Mr./N	Last		First		Middle	<u> </u>	
City State Zip    Work Number (	SSN:	Race:N	/larital Status:_		of Birth:/_	/Age:		
City   State   Zip   Work Number   Cell phone No.   Work Number   Date of Last Visit:   Are you a diabetic?   Yes   No   How long a diabetic?   Do you use insulin?   Pharmacy Name and City:   Your Emergency Contact & Number:   Insurance Subscriber Information (if different than patient)   Name:   Secondary:   Insurance Subscriber Information (if different than patient)   Name:   SS#:   DOB:   Relationship:   SS#:   DOB:   Relationship:   SS#:   No   If Yes:   Have you ever been hospitalized or had a major operation?   Yes   No   If Yes:   Have you ever experienced 2 falls OR any falls with injury in the last year   Yes   No   If Yes:   Is your pneumonia vaccination up to date?   Yes   No   If Yes:   Yes   No   If Yes:   Do You use tobacco?   Yes   No   Medications/Dosage/Frequency: (Prescription and Non-Prescription)   Medications/Dosage/Frequency:   Prescription and Non-Prescription   Any treatment?   Are you currently taking a blood thinner?   If so what amount?   ALLERGIES?   Penicillin   Yes   No   Anesthetics   Yes   No   Ibuprofen   Yes   No   Other   Sulfa   Yes   No   Tapes   Yes   No   Lidocane   Yes   No   Assirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Assirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Assirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Assirin   Yes   No   Contisone   Yes   No   Lidocane   Yes   No   Assirin   Yes   No   Contisone   Yes   No   Contisone   Yes   No   Assirin   Yes   No   Contisone   Yes   No   Contisone   Yes   No   Assirin   Yes   No   Contisone   Yes   No   Contisone   Yes   No   Assirination and administer any necessary procedures.   X:	Address:							
Cell phone No. ( )			Cit	V	State	Zi	0	-
Are you a diabetic?	Home No. ()	Ce						
Are you a diabetic?	Family Physician: Dr.		Lo	ocation	Date	of Last Visit:		
Primary Insurance:								
Primary Insurance:	Pharmacy Name and City:			Your Emerge	ncy Contact	& Number:		
Primary Insurance:	namacy name and only.					<u></u>		
Insurance Subscriber Information (if different than patient) Name:	Primary Insurar	nce:						
Are you ever been hospitalized or had a major operation?   Yes   No   If Yes:   Have you ever been hospitalized or had a major operation?   Yes   No   If Yes:   Have you ever experienced 2 falls OR any falls with injury in the last year   Yes   No   If Yes:   Is your influenza vaccination up to date?   Yes   No   If Yes:   Is your pneumonia vaccination up to date?   Yes   No   If Yes:   Is your pneumonia vaccination up to date?   Yes   No   If Yes:   Yes   No   Medications/Dosage/Frequency: (Prescription and Non-Prescription)    What is your current problem?   Any treatment?   Any treatment?   Are you currently taking a blood thinner?   If so what amount?   ALLERGIES?   Penicillin   Yes   No   Anesthetics   Yes   No   Ibuprofen   Yes   No   Other   Sulfa   Yes   No   Tapes   Yes   No   Codeine   Yes   No   Aspirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Aspirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Aspirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Aspirin   Yes   No   Cortisone   Yes   No   Lidocane   Yes   No   Aspirin   Yes   Yes   Yes   Yes   No   Cortisone   Yes   No   Aspirin   Yes   Yes	Insurance Sub	scriber Informa	tion (if differ	ent than patient)				
Are you currently taking a blood thinner?  Allergies?  Penicillin Yes No Anesthetics Yes No If yes No If yes:  Sulfa Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No Codeine Yes No Anesthetics Yes No Lidocane Yes No Assirin Yes No Assirin I verify that the above information and medical history is correct to the best of my knowledge give my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.  X:			SS#:	•		Relationshi	p:	
Are you currently taking a blood thinner?  Allergies?  Penicillin Yes No Anesthetics Yes No If yes No If yes:  Sulfa Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No If Yes:  If so what amount?  Assirin Yes No Codeine Yes No Anesthetics Yes No Lidocane Yes No Assirin Yes No Assirin I verify that the above information and medical history is correct to the best of my knowledge give my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.  X:	(First)	(M) (La	st)					
Have you ever experienced 2 falls OR any falls with injury in the last year		an's care now?			Yes [	No If Yes: _		
Is your influenza vaccination up to date?				ion?	∐ Yes L	No If Yes: _		
Is your pneumonia vaccination up to date?			y falls with in	jury in the last ye	ear 🔛 Yes 🗀	No If Yes: _		
Do You use tobacco?					∐ Yes L	No If Yes: _		
Medications/Dosage/Frequency: (Prescription and Non-Prescription)  What is your current problem?  How long have you had this problem?  Are you currently taking a blood thinner?  Are you currently taking a blood thinner?  Penicillin  Yes No Anesthetics Yes No Ibuprofen Yes No Other  Sulfa Yes No Tapes Yes No Codeine Yes No Aspirin  Aspirin  Aspirin Yes No Cortisone Yes No Lidocane Yes No Aspirin Yes No Cortisone Yes No Codeine Yes No No Codeine Yes No C	Is your pneumonia vacci	nation up to date	?		☐ Yes ☐	J No If Yes: _		
What is your current problem?  How long have you had this problem?  Are you currently taking a blood thinner?  If so what amount?  ALLERGIES?  Penicillin  Yes No Anesthetics Yes No Ibuprofen Yes No Other  Sulfa Yes No Tapes Yes No Codeine Yes No Aspirin  Aspirin  Yes No Cortisone Yes No Lidocane Yes No Aspirin  ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize releas any medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge give my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.  X:								
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Are you currently taking a blood thinner?  If so what amount?  ALLERGIES?  Penicillin	What is vour current p							
Are you currently taking a blood thinner?  ALLERGIES?  Penicillin	How long have you h	ad this proble	m?		ny treatme	nt?		
Penicillin Yes No Anesthetics Yes No Ibuprofen Yes No Other Sulfa Yes No Codeine Yes No Codeine Yes No SSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize releasing medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge ive my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.	10 w tong have you m	ia inis probier	<i></i>		ing treatme			
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Aspirin  Yes No Cortisone  Yes No Lidocane  Yes No Lidocane  ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize releasing medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge give my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.					-		Other	
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		Y 4 TT • T •			<b>70.</b> /	n. —		Shoes
Staff Initial Date Current Height: Current Weight: B/P: Temp. Shoes		HERONT HOTOMAS	17	irrout Wolaut.	N/	r. T	uwn	NOOC '

## **2023 REVIEW OF SYSTEMS/ CURRENT PROBLEMS:**

None of the A	bove Patient Name:
Allergic/Immunologic (Please circle all that apply): Difficulty Healing	Seasonal Allergies
Heat/Cold intolerance	Increased Thirst (Polydipsia)
Endocrine (Please circle all that apply):  Excessive Sweating	Increased skin pigmentation
Endopping (Plage single all that are led).	
Numb Feet	
Easy to Fall	Weakness in Feet
Neurological (Please circle all that apply):  Burning in Feet	Tingling in Feet
Rashes	Wart(s)
Integumentary (Please circle all that apply): Atypical moles	Sores on foot or leg
Leg Pain (shin splints)	Muscle Aches
Flat Feet Joint Pain	Swelling leg "Toe-in" or "Toe-out" gait (walking)
injuries)	Swelling in joint
Ankle Instability (easy twisting	Pain in feet getting out of bed
Musculosketal (Please circle all that apply):	
Diarrhea	Vomiting
Gastrointestinal (Please circle all that apply):  Abdominal Pain	Nausea
	Linpitysema
Respiratory (Please circle all that apply): Shortness of Breath/Difficulty breathing	Emphysema
	Varicose Veins
Leg Cramps	Swelling in feet/legs (Edema)
Discoloration of toes/foot	exercise/activity
Cardiovascular (Please circle all that apply):  Chest Pain	Pain or fatigue in feet/legs with
Lastry Them I magae	2.15011 \$ 11.00110
Chills Easily Tired/Fatigue	Fever Night Sweats
Constitutional (Please circle all that apply):	Favor