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:

Patient Name: Dr./Mr./Mrs./Ms. _____
Last First Middle

SSN: _____-_____-_____Race:_____Marital Status:_____ Date of Birth: ____/____/_____Age: _____

Address: _____ _____ _____ _____
City State Zip

Home No. (___)____ _____ Cell phone No. (___)_____ Work Number (___)_____

Family Physician: Dr._____ Location_____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 Information

Primary Insurance: _____ Secondary: _____

Insurance Subscriber Information (if different than patient)

Name: _____ SS#: _____ DOB: _____ Relationship: _____
(First) (M) (Last)

Are you under a physician's care now?	☐ 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: _____

Do You use tobacco? ☐ Yes ☐ No

Medications/Dosage/Frequency:(Prescription and Non-Prescription)

_____ _____ _____
_____ _____ _____
_____ _____ _____

What is your current problem? _____

How long have you had this problem? _____*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 ☐	

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize release of 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. I give my permission to the named provider(s)at Family Foot Center to perform and administer any necessary procedures.

X: _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____

Staff Initial ***Date*** ***Current Height: _____ Current Weight: _____ B/P: _____ Temp. _____Shoes Size: ____***

2023 REVIEW OF SYSTEMS/ CURRENT PROBLEMS:

Constitutional (Please circle all that apply):

Chills
Easily Tired/Fatigue
Fever
Night Sweats

Cardiovascular (Please circle all that apply):

Chest Pain
Discoloration of toes/foot
Leg Cramps
Pain or fatigue in feet/legs with exercise/activity
Swelling in feet/legs (Edema)
Varicose Veins

Respiratory (Please circle all that apply):

Shortness of Breath/Difficulty breathing
Emphysema

Gastrointestinal (Please circle all that apply):

Abdominal Pain
Diarrhea
Nausea
Vomiting

Musculosketal (Please circle all that apply):

Ankle Instability (easy twisting injuries)
Flat Feet
Joint Pain
Leg Pain (shin splints)
Pain in feet getting out of bed
Swelling in joint
Swelling leg
"Toe-in" or "Toe-out" gait (walking)
Muscle Aches

Integumentary (Please circle all that apply):

Atypical moles
Rashes
Sores on foot or leg
Wart(s)

Neurological (Please circle all that apply):

Burning in Feet
Easy to Fall
Numb Feet
Tingling in Feet
Weakness in Feet

Endocrine (Please circle all that apply):

Excessive Sweating
Heat/Cold intolerance
Increased skin pigmentation
Increased Thirst (Polydipsia)

Allergic/Immunologic (Please circle all that apply):

Difficulty Healing
Seasonal Allergies

☐ **None of the Above**

Patient Name: _____
Date: _____, 2024