**Atrium Foot Specialists**
**Medical History Questionnaire**

Name: _____ Date of Birth: / / Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact (check one): ☐Home Phone ☐Cell Phone

Social Security #: _____ Email: _____

Gender (check one): ☐Male ☐Female Height: _____ Weight: _____

Primary Care Physician: _____ Date last seen: _____

Primary Care Phone: _____

Referred By: _____ Relationship: _____

Pharmacy Name: _____ City: _____ Pharmacy Phone: _____

Occupation: _____ Employer: _____

Please Check One: ☐ Part time ☐ Full time ☐ Student ☐ Retired ☐ Disabled ☐ N/A

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unspecified ☐ Prefer not to answer

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ French ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Spanish

**Reason for Visit Today**: _____

When did the problem start? _____ Has this been treated before? ☐ Yes ☐ No

Was there any injury? ☐ YES ☐ NO Any previous imaging (Xray or MRI)? _____

**Medications (please provide a list or fill in below)**: Are you on Blood Thinners? ☐ Yes ☐ No

_____ _____

_____ _____

_____ _____

_____ _____

**Allergies**: ☐ None Known Drug Allergies

☐ Penicillin Reaction: _____ ☐ Other (list below)

☐ Local Anesthesia Reaction: _____ _____ Reaction: _____

☐ Aspirin Reaction: _____ _____ Reaction: _____

☐ Codeine Reaction: _____ _____ Reaction: _____

**Past Foot/Leg History (Please mark all that apply)**:

☐ **Overall Healthy**
☐ Diabetic Foot Infection
☐ Neuropathy
☐ Wounds or Ulcer(s)
☐ Foot Fracture
☐ Ankle Fracture
☐ Foot Surgery
☐ Ingrown Nail(s)
☐ Bracing
☐ Drop Foot
☐ Blood Clot in Leg
☐ Pulmonary Embolism

If yes, Procedure Name(s) or Problem(s) corrected: _____

**General Surgeries/Operations**:

_____

_____

**Hospitalizations outside of surgery in the last 5 years**:

_____

_____

**Past Medical History (Please mark all that apply)**

- ☐ **No History of illness, no medical conditions**
- ☐ Anemia
- ☐ Artificial Joints/Implants
- ☐ Arthritis
- ☐ Heart Arrhythmia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Headache/Migraine
- ☐ Hearing Loss
- ☐ Heart Attack
  When: _____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Pacemaker
  Year implanted: _____
- ☐ Psychiatric Disorder
- ☐ Radiation Treatment
- ☐ Skin Cancer
- ☐ Stroke
  When: _____
- ☐ Thyroid Disease

Other: _____

**Social History**:

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐Widow

Smoking: ☐ Current Every Day Smoker ☐ Former Smoker ☐ Never Smoked

If yes, for how many years did you/have you smoked? _____How much per day? _____

Alcohol Use: ☐ Yes ☐ Former ☐ Never If yes, what and how often? _____

Drug Use: ☐ Current ☐ Former ☐ Never If yes, what and how often? _____

**Family History for First Degree Relatives (parent, sibling, aunt, uncle):**

Mother Living? ☐ Yes ☐ No If no, cause of death? _____

Father Living? ☐ Yes ☐ No If no, cause of death? _____

- ☐ Diabetes If yes, whom? _____
- ☐ Heart Disease If yes, whom? _____
- ☐ Cancer If yes, whom? _____Type: _____

**Review of Systems (Please mark all that apply)**

**Eyes**
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glasses
- ☐ Contact Lens
- ☐ Dry Eyes

**Ear, Nose, and Throat**
- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Nose Bleeds

**Cardiovascular**
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat

**Constitutional**
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Weight Gain/Loss
- ☐ Chills

**Respiratory**
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

**Gastrointestinal**
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Jaundice/ Hepatitis

**Genito-Urinary**
- ☐ Pain/Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ History of STD's

**Endocrine**
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating

**Blood/Lymph nodes**
- ☐ Easy Bruising
- ☐ Gums Bleed Easy
- ☐ Prolonged Bleeding

**MusculoSkeletal**
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain/Swelling

**Skin**
- ☐ Rash/Sores
- ☐ Lesions
- ☐ Hives
- ☐ Eczema

**Neurological**
- ☐ Seizures
- ☐ Weakness/Paralysis
- ☐ Numbness
- ☐ Tremors

**Immunologic**
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

**PATIENT AUTHORIZATION**

I give my permission to Atrium Foot Specialists to examine and treat me for my foot/ankle problem(s). I further give Atrium Foot Specialists permission to perform any needed test(s) that aid in diagnosis and treatment of my foot/ankle condition(s).

It is the responsibility of the patient to know his/her insurance requirements for referrals, precertification, network providers and limitations of coverage. We will try to assist you in any way possible, but please understand that there are hundreds of insurance plans on the market and it is impossible for us to know all the details of all insurance policies.

My signature below acknowledges that I am aware that I am ultimately responsible for charges whether covered OR NOT by insurance. I authorize any medical benefits to which I am entitled to be paid directly to Dr. Michael Singerman. I also authorize Dr. Michael Singerman to release any and all information necessary to secure payment for charges incurred.

Print Name: _____

Signature: _____ Date: _____

If you are not the patient who signed above please provide below:

Printed Name: _____ Relationship: _____

Are you their Medical Power of Attorney: ☐ yes ☐ No Phone: _____