

**Cary Foot and Ankle Specialists
Patient Medical History**

Today's Date _____

Name _____ Age _____ Sex _____

Height ____' ____" Weight _____ Shoe Size _____ Type of shoe worn most often: _____

Chief Complaint (What foot/ankle problem brought you to this office?) _____

How long have you had this problem? _____

Have you received prior treatment from a physician or treated it yourself? _____

What type of treatments have you tried? _____

Please Rank your pain: 1 (no pain) 2 3 4 5 6 7 8 9 10 (severe pain)

Describe the nature of your pain: Burning Throbbing Sharp Continuous Intermittent Other: _____

When is the pain worse (any particular times of day?) _____

Who is your Primary Care Physician/ **Physician's Office** and approximate date last seen?

Do we have your permission to send a letter to your physician regarding this office visit? Yes ___ No ___

Do you have DIABETES ? Yes ___ No ___ How many years? _____ Last blood sugar _____

Do you have any of the conditions below? (Circle if applicable)

- | | | |
|-------------------------------|-----------------------|-----------------------|
| Arthritis | Hepatitis | Seizures |
| Asthma | High Blood Pressure | Sickle Cell Anemia |
| Back Problems | HIV Positive | Stomach Problems |
| Bleeding Disorders | Kidney Trouble | Stroke |
| Blood Clots/ Poor Circulation | Liver Trouble | Thyroid |
| Cancer | Lung Problems | |
| Cholesterol | Mitral Valve Prolapse | For Women: |
| Gout | Numbness in Feet | Are you pregnant? Y N |
| Heart Disease | Previous Drug Use | |

Other medical conditions: _____

Most recent surgeries or hospitalizations (include dates): _____

Please list all medications you are currently taking: _____

PLEASE CIRCLE Allergies to medications that you may have:

- | | | | | |
|--------------|---------------|-------------------|---------|--------------|
| No Allergies | Penicillin | Antibiotics | Codeine | Latex |
| Aspirin | Adhesive Tape | Local Anesthetics | Sulfa | |
| Other _____ | | | | |

Do you currently smoke or have you discontinued use of cigarettes? (packs/day/year) _____

Do you currently drink alcohol or have you discontinued use of alcohol? (drinks/day/year) _____

What is your current occupation? _____

Please circle any conditions that are present in your FAMILY MEDICAL HISTORY:

- | | | | |
|--------------|---------------|--------------------|----------------------|
| Diabetes | Heart Disease | Bleeding Disorders | Circulatory Problems |
| Hypertension | Cancer | Gout | Other _____ |

Other Notes/Comments: _____

Cary Foot and Ankle Specialists Patient Medical History

Review of Systems

Please check all of the following that you are currently experiencing or have recently experienced.

Constitutional:	Y	N	Eyes:	Y	N
Generally do you feel well?			Do you wear glasses or contacts?		
Do you feel fatigued during the day?			Do you have burning or itching eyes?		
Does your problem limit your normal daily activities?			Do you have sensitivity to light?		
Cardiovascular:	Y	N	Are your eyes frequently red?		
Have you noticed your legs and ankles swelling?			Ears, Nose, Mouth, & Throat:	Y	N
Do you have varicose veins?			Do you have ringing in your ears?		
Do you have cramping in your legs at night or at rest?			Do you get nosebleeds?		
Do you have cramping in your legs when walking?			Do you have difficulty swallowing?		
Respiratory:			Gastrointestinal:	Y	N
Do you have chest pain?			Do you have a loss or increase in appetite?		
Do you have difficulty breathing?			Do you have a history of stomach ulcers?		
Musculoskeletal:	Y	N	Do you have heartburn?		
Do you have low back pain?			Do you have bloody or dark stools?		
Do you have pain in your legs?			Genitourinary:	Y	N
Do you have general muscle aches or pains?			Do you urinate more frequently than before?		
Have you noticed a change in the way you walk?			Do you have pain with urination?		
Is it difficult to climb stairs?			Have you noticed blood in your urine?		
Are you experiencing a loss of strength in your legs?			Neurological:	Y	N
Do you limp when you walk?			Do you ever feel dizzy?		
Do your shoes wear out quickly or unevenly?			Do you often feel confused or disoriented?		
Integumentary (Skin):	Y	N	Do you have problems with your balance?		
Do you have any skin problems?			Do you have frequent or reoccurring headaches?		
Do you have any skin rashes?			Do you have seizures?		
Do you have any moles, lumps, or bumps on your skin?			Do your legs often feel like they "are going to sleep"?		
Do you have extremely dry skin or cracking?			Do you have numbness in your legs?		
Do you have any open skin sores?			A feeling of burning in your legs?		
Are there unusual areas of discoloration on your skin?			Experience shooting pains down your legs?		
Do you have problems with your fingernails?			paralysis (complete loss of muscle strength in legs)		
Immunologic:	Y	N	Psychiatric:	Y	N
If you get cut, does it take a long time to heal?			Do you have a history of psychiatric problems?		
Endocrine:			Are you subject to mood swings?		
Are you excessively thirsty?			Are you under a lot of stress?		
Do you sweat excessively?			Hematologic/ Lymphatic:		
Do you have swollen glands?			Do you bruise easily?		
Have you had a significant weight change recently?			Do you use compression stockings?		

To my knowledge, the above information is correct and by signing below I consent to treatment by Dr. Michael Tomey. (If patient is a minor, parent/guardian must sign)

Signature: _____ Date: _____

**Cary Foot and Ankle Specialists
Patient Information**

Today's Date _____

Patient Information:

Name: Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip code _____

Home Phone# _____ Cell # _____ Email Address: _____

Appointment Reminders Via: Text (Cell Phone) Automated Phone Email

Date of Birth ____/____/____ Gender M / F SS# _____ (patient or guardian)

Marital Status: Married Single Separated Widowed Divorced Minor

Student: Full Time Part Time Grade: _____ Race: Asian/ Black/ Hispanic/ White/ Other: _____

Primary Insurance

Name of Primary Person on Insurance: _____ Date of Birth of Primary: _____

Relationship to the patient: Self Spouse Parent/Guardian Other: _____

Patient or Guardian Employer: _____ Work Phone: _____

Who should we contact in case of emergency? _____ Phone: _____

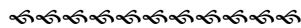
Relationship to the patient: _____

How did you hear about our practice? _____

Did a patient or physician refer you to our practice? (Please name) _____

Patient Financial Agreement

I authorize Cary Foot and Ankle Specialists to file a computerized claim form (paper or electronic) on my behalf. I authorize benefits to be paid to me or on my behalf to the provider for covered services. I authorize the release of any medical information to my carrier or its agents needed to determine benefits.



Our financial policy requires payment on the day services are rendered. We will call your insurance company to verify coverage and benefits. You will be responsible for your co-pay, co-insurance, and any unmet deductible, as applicable. Please note: Failure to show up for a scheduled appointment without 24 hours prior notification there will be a \$45.00 fee. I understand the financial policy as noted above.

X _____
Signature of Responsible Party

Date

Notice of Privacy Practices

I understand that per Federal HIPAA guidelines, CFAS, its employees and Nuesoft Technologies Inc, to ensure patient privacy and do not allow other patients or individuals in other medical practices to view disclosed information without your permission. I hereby acknowledge that I have been offered a copy of CFAS's **Notice OF Privacy Practices**. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that CFAS will offer me updates to this NOPP should it be amended.

X _____
Signature of Responsible Party

Date