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? ____

What athletic activities do you participate in? ____

How often? ____ Daily ____ Weekly ____ Monthly Avg. Distance Run ____________________

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 Progressive

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 ________ Last HgbA1C ___________

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 ________________

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__________

Phone#______________________________________ Email Address: _______________________________________

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:____________

Pharmacy Information

Name of Pharmacy ______________________________ Phone # (if known) __________________________________

Pharmacy Address ____

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 AthenaNet 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 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

Cary Foot and Ankle Specialists
Patient Information

Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: ____________________________________ Birth Date: ________________

I HEREBY AUTHORIZE Cary Foot and Ankle Specialists TO SHARE:

- □ Any of my medical information
- □ My lab results
- □ My appointment times, dates, and reasons for the visits
- □ The medications I am taking
- □ Financial/Billing Information
- □ The following information (specify): ____

WITH THE FOLLOWING PEOPLE:

Full Name: ____ Relationship:__________________

Full Name: ____ Relationship:__________________

Full Name: ____ Relationship:__________________

Full Name: ____ Relationship: _________________

I understand that I may cancel this consent at any time (by writing to Cary Foot and Ankle Specialist), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider to share my information with someone.

This authorization expires:

□ When I cancel it in writing

□ Specified Date: ___________

If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

Signature:____ Date: ___________________

Relationship to minor patient (if parent or legal guardian):* ___________________________________

If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: ____ Date: ___________________