Davis Foot & Ankle Centers, Inc

Name_____ Age___ Date of Birth_____ Today's date_____

SS # _____ Sex: ___ Male or ___ Female

Home Address _____

City _____ State _____ Zip code_____

Phones: Home _____ Cell _____

May we leave a message? Y or N

Email address:_____

Ethnicity: Hispanic/Latino Y or N Race:_____ Primary Language:_____

Marital Status:_____ Student: Y or N Employment status:_____

Emergency contact: Name_____relation _____ Phone _____

If patient is a minor, please list the following:

Father's name:_____ phone # _____

Mother's name:_____ phone # _____

INSURANCE INFORMATION

Primary Insurance company_____ ID#_____

Name of policy holder_____DOB_____SS#_____

Employer name_____Employer phone #_____

Secondary Insurance company_____ID#_____

Name of policy holder_____DOB_____SS#_____

Employer name_____Employer phone #_____

HISTORY OF PRESENT ILLNESS

What is the reason for your visit today? _____

When did you first notice this problem? _____

How did this problem begin? _____

Is this problem painful? Y or N

Have you experienced this before? Y or N

Location of pain? _____

Were you treated for this before? Y or N

Intensity of pain: 0 1 2 3 4 5 6 7 8 9 10

Does it interfere with regular activity? Y or N

What makes it worse? _____

What makes it better? _____

Have you recently experienced? ___fever ___ chills ___nausea/vomiting

___weight loss ___night sweats

Have you ever experienced the following symptoms in the past year?

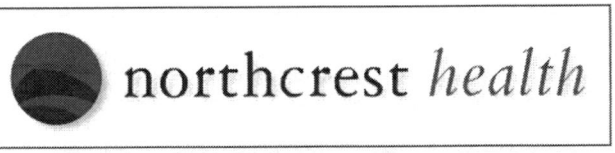
___ Joint pain If yes, where?_____

___ Difficulty walking

___ Limited movement If yes, where?_____

SHOE SIZE _____

Assessment Form



Contact Information	
Patient Name:	Date of Birth:_____ Age:___ Gender: ☐ M ☐ F
Phone #1:_____ Best time to Call: AM/PM May we leave a message? Yes No	Phone #2:_____ Best time to Call: AM/PM May we leave a message? Yes No
Primary Language: English Spanish Other_____	

	Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:	**YES**	**NO**
PERSONAL HISTORY	Have you or a family member ever had a problem with anesthesia? Malignant Hyperthermia?		
	Do you have metal anywhere in your body (plates, screws, joint replacements, and vascular stents)?		
	Have you ever been diagnosed with sleep apnea?		
	Do you use a CPAP machine?		
	Do you have a Living Will or Advance Directive?		
	Do you have Home Health visiting you at present?		
	Do you ever feel threatened by your partner, child, caregiver or anyone in your home?		
	Do you have any physical restrictions?		
	What would you consider your level of activity to be? Very Light Light Moderate High		
	Do you live alone?		
	Do you need help with your normal daily activities?		
	Do you use a wheelchair, walker or cane on a regular basis?		
	Do you have any culture or religious practices that are important to you during your visit with us? _____		
	Would you accept blood products/transfusion if needed?		
	Do you smoke or vape? Packs/Day_____ How many yrs? _____		
	Do you drink alcohol? How much? _____ How often? _____		
	Do you use recreational drugs? Specify:_____		
	How do you like to learn new things? Reading Watching Listening Doing		
	What pharmacy do you use?		
	Primary Care Physician:		
	Vaccines:(Date) Pneumonia:_____ Influenza: _____ Tetanus: _____ COVID: _____		

Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:		YES	NO
HEART	Do you see a Cardiologist? Who:_____ Last Visit: _____ Last EKG:_____		
	Ankle Swelling		
	Congenital Heart Problems		
	High Cholesterol		
	High blood pressure or vascular disease		
	Heart valve disease (ex: Tricuspid, Mitral, Aortic, or Pulmonic valve)		
	Congestive heart failure		
	Irregular heartbeat		
	Do you have a cardiac pacemaker or defibrillator?		
	Aneurysms of the brain or vasculature (ex: Aortic aneurysm)		
	Coronary artery disease. If so, have you had heart bypass surgery (CABG)? **YES or NO**		
	Do you experience chest pain or tightness at any time? (ex: while resting, exercising)		
	Do you experience shortness of breath at any time? (ex: while resting, exercising)		
	Have you ever had a heart attack? If so, when (month/year)? _____		
	Do you have any cardiac stents? If so, when were they placed (month/year)? _____		
LUNGS	Recent respiratory infection/Pneumonia		
	Chronic Obstructive Pulmonary Disease (COPD)		
	Chronic Bronchitis or Empysema		
	Severe Asthma (ex: requiring Emergency Room treatment)		
	Tuberculosis		
	Do you wear oxygen at home? If so,_____L/min		
	Have you been diagnosed with Sleep Apnea? If so, do you wear a CPAP? **YES or NO**		
NEURO	Paralysis/Weakness		
	Frequent Headaches/Migraines		
	Alzheimer's Disease		
	Seizure disorder (ex: Epilepsy)		
	Have you ever had a stroke (CVA) or mini-stroke (TIA)		
	Multiple sclerosis, muscular dystrophy, myasthenia gravis or other muscular disorders		
	Neuropathy (numbness) of the hands, feet, or legs		
	Chronic back pain, neck pain, or scoliosis		
	Severe anxiety or depression		
	Post-Traumatic Stress Disorder (PTSD) or Claustrophobia		
	Chronic Pain Syndrome or Fibromyalgia		

	Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:	YES	NO
ENDOCRINE/GI/RENAL	Hyperthyroidism or Hypothyroidism		
	Diabetes. If so, do you require insulin for treatment? **YES or NO**		
	Gastroesophageal Reflux (GERD) or severe Heart Burn/Indigestion		
	Hiatal Hernia		
	Ulcers of the stomach		
	Liver disease (ex: Hepatitis, Cirrhosis)		
	Prostate problems		
	Blood in urine		
	Frequent infections		
	Kidney disease		
	Kidney Failure		
	Are you currently receiving dialysis? If so, last treatment date (day/month)? ____		
	Kidney Stones		
	Frequent urination, urgency or leakage		
HEME	Bleeding disorders (ex: Anemias or Clotting disorders)		
	Blood clots (ex: Deep Vein Thrombosis or Pulmonary Embolism)		
	Are you currently taking blood thinners? (ex: Aspirin, Warfarin, Eliquis, Plavix)		
	Have you ever received a blood transfusion?		
	Autoimmune or Connective tissue disorders (ex: Lupus, Rheumatoid Arthritis)		
	Infectious diseases (ex: Hepatitis, HIV/AIDS, MRSA, VRE)		
SKIN/BONE	Sore that won't heal		
	Open wound		
	Wound Care Patient Current Past		
	Arthritis/Gout		
	Foot problems		
MISC	As a child, were you diagnosed with any congenital abnormalities		
	History of alcohol or drug abuse		
	Are you currently receiving radiation or chemotherapy?		
	Have you ever received radiation to the face, neck, or upper chest?		
	Do you have any implantable devices? (ex: bladder/spinal cord stimulator, insulin pump)		
	Last menstrual cycle? _____ Hysterectomy Post-Menopausal		
	Are you pregnant? Yes No		

	Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:	**YES**	**NO**
EYES/ENT	Eye disorders or recent injuries (ex: Glaucoma, Retinal detachment, Lens transplant)		
	Blurred or double vision		
	Cataracts		
	Blindness/Macular Degeneration		
	Ear problems		
	Loss of hearing		
	Loss of balance		
	Hoarseness		
	Difficulty swallowing		
	Sinus problems		
ANESTHESIA	Have you ever had neck surgery, jaw surgery, or nose surgery?		
	Have you ever been told you were a difficult airway by other anesthesia providers?		
	Do you experience nausea and vomiting post-op after receiving anesthesia?		
	Have members of your family ever had life threatening problems with anesthesia?		
	Have you ever had life threatening problems with anesthesia? (please describe below)		
	Please list any additional complications from anesthesia, health concerns, or questions you may have for the Anesthesia provider in the space provided below.		
FAMILY HISTORY	Heart disease: Mother Father		
	High blood pressure: Mother Father		
	Kidney disease: Mother Father		
	Blood disease: Mother Father		
	Diabetes: Mother Father		
	Thyroid disease: Mother Father		
	Mental illness: Mother Father		
	Neurological disease: Mother Father		
	Cancer – Type: _____		
	Other: _____		

Please list all Allergies and Reactions in the space provided below.

ALLERGIES	Allergies	Reaction
	1)	
	2)	
	3)	
	4)	
	5)	
	6)	

Please list all Medications, Supplements, or Herbals you are currently taking in the space provided below.

MEDICATIONS	Name, Dose & Frequency	
	1)	8)
	2)	9)
	3)	10)
	4)	11)
	5)	12)
	6)	13)
	7)	14)

Surgeries, Implantable Devices, and Metal Implants in the space provided below. Check all that apply.

NONE	Colonoscopy/EGD	Kidney Removal	Total Hip Left Right
Aneurysm (AAA)	Colon Resection	Cystoscopy	
Angiogram (other than heart)	Mastectomy Left Right	Cataract Left Right	Total Knee Left Right
Heart Bypass	Hernia	Prostate	Arthroscopy Knee Shoulder
Heart Cath/Stents	Hemorrhoidectomy	Lithotripsy	
Pacemaker/Defibrillator	Laparoscopy	D & C	Foot, Ankle or Knee
Fem/Pop Bypass	Breast Biopsy	Hysterectomy	Hand or Wrist
Heart Valve	Appendectomy	Tubal Ligation	Shoulder or Elbow
Carotid Left Right	Gallbladder	Cesarean Section	Carpel Tunnel Release
Silverhawk	Amputation	Spine (Back/Neck)	Ear tubes
AV Grafts	Splenectomy	Spinal Injections	Sinus
Gastric Bypass	Bladder Repair	Ablation	Tonsils and Adenoids
Thyroid	Other:		

For Office Use:

Please Indicate Below If Surgeon Is Requesting Any Clearances Or Testing Be Completed Prior To Surgery

Cardiac Clearance **Medical Clearance** **Pulmonary Clearance** **Pre-Admission Testing**

PAT Date: _____

Notice of Privacy Practice Acknowledgement

Davis Foot and Ankle Centers, Inc.

We keep a record of Health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so our unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting Medical Records.

Our NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used and disclosed, and how you can access this Information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature:

_____

Printed Name if signed on behalf of patient

_____

Relationship (parent, legal guardian, Personal representative, etc.)

_____

(Notation, if any, by staff)

This form will be retained in your medical records.
Privacy Act 04/2003
Date: