Athens Podiatry

Dr. Mauro Rossi DPM

Medical Record #_____

Name: _____ Age: _____ DOB: ___/___/___

Address: _____ SSN: _____-_____-_____

_____ Sex: M / F Shoe Size: _____

Phone #: ( ) - HOME / MOBILE / WORK HEIGHT: _____ WEIGHT: _____

Phone #: ( ) - HOME / MOBILE / WORK Pharmacy Name: _____

Phone #: ( ) - HOME / MOBILE / WORK Pharmacy City / State: _____

EMPLOYER: _____ RETIRED: Y / N DISABLED: Y / N Disability: _____

Insurance Provider: _____ HMO / PPO Email: _____

Primary Care Physician: _____ Referral: Y / N

Emergency Contact: NAME: _____ PHONE: _____ Relation _____

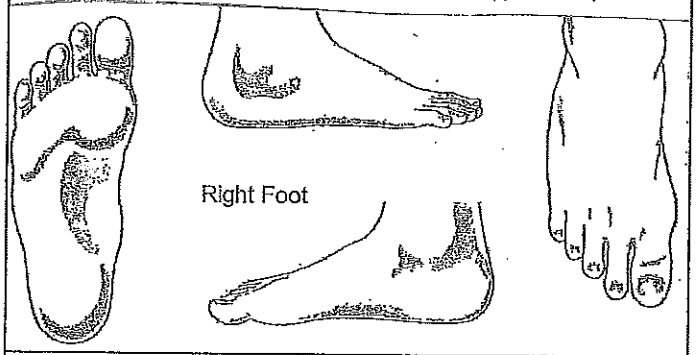
Problem 1: DURATION:

Pain: NO PAIN SHARP DULL BURNING ACHING THROBBING

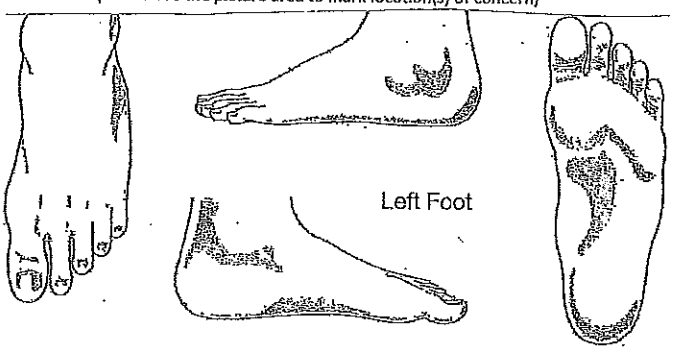
Problem 2: DURATION:

Pain: NO PAIN SHARP DULL BURNING ACHING THROBBING

RIGHT FOOT (Please use the picture area to mark location(s) of concern)



LEFT FOOT (Please use the picture area to mark location(s) of concern)



Past Medical History (Please check all that apply)

Date Last Seen by PCP: ___/___/_____

____ Alzheimer's	____Diabetes	____Heart Disease	____Raynaud's Disease
____Anemia	-____Insulin	____**Hepatitis A / B / C**	____Reflux
____Arthritis	-____Oral Meds	____High Blood Pressure	____Rheumatic Fever
-____Lupus	-____Diet	____Keloid	____Scarlet Fever
-____Rheumatoid	-A1C _____	____Kidney Disease	____Skin Disorders
____Back Problems	____Dialysis	____Liver Disease	____Stroke
____Blood Thinners	____Emphysema	____Lung Disease	-Year _____
-____Coumadin	____Epilepsy	____Mitral Valve Prolapse	____Swelling Legs
-____Plavix	____Fibromyalgia	____Multiple Sclerosis	____Thyroid Disorder
____Blood Transfusion	____Foot Amputation	____Neuropathy	____Tuberculosis
____Cancer	____Foot Infection	____Osteoporosis	____Varicose Veins
-Type_____	____Foot Ulcer(s)	____Phlebitis	OTHER: _____
____Cerebral Palsy	____Glaucoma	____Pregnant	_____
____COPD	____Gout	-Breastfeeding Y / N	_____
____Depression	____Heart Attack	____Psoriasis	_____
____Dementia	-Year_____	____Psychiatric Disorders	_____

Surgical History: (If other please specify)***

____Amputation ____Heart Bypass ____Heart Valve Replacement ____Hip Replacement ____Knee Replacement

____Pacemaker ____Foot Surgery ____Oral Surgery ____Gall Bladder ____Hysterectomy ____C-Section

OTHER: _____

Social History:

Do you use tobacco products?: Y / N If yes please specify: _____ Former Smoker? Y / N

Do you drink alcohol? Y / N If yes, specify frequency: _____ Former Drinker? Y / N

Do you use illegal drugs? Y / N If yes, please specify: _____ Former User? Y / N

Family Health History:(Only immediate family history is necessary)***	Mother	Father	Sister	Brother
Anemia				
Arthrtis				
Bunions				
Cancer				
Diabetes				
Dimentia				
Flatfeet				
Hammertoes				
Heart Disease				
High Blood Pressure				
Parkinson's				

Allergies: (if checked yes, specify reaction)*

____NONE
____BETADINE: _____
____SULFA: _____
____TAPE: _____
____ASPIRIN: _____
____CODEINE: _____
____PENICILLIN: _____
____LIDOCAINE: _____
____MARCAINE: _____
____OTHER: _____

Medication(s): I Brought a medication list (as requested) YES / NO

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Review of Systems:

Constitutional:
____Recent Weight Change
____Fever
____Fatigue

Eyes:
____Eye Disease or injury
____Wears Glasses / Contacts
____Blurred / Double Vision

Ear / Nose / Mouth / Throat:
____Hearing loss / ringing
____Swollen glands in neck

Cardiovascular:
____Swelling of feet/ankles/hands
____Chest pain
____Palpitation
____Shortness of breath

Respiratory:
____Chronic/Frequent cough
____Shortness of Breath
____Wheezing

Gastrointestinal:
____Appetite Loss / Gain
____Nausea / Vomitting
____Abdominal Pain

Genitourinary:
____Kidney Stones
____Frequent Urination

Skin:
____Rash(es)/Itching
____Change in skin color
____Change in hair/nails
____Varicose Veins

Musculoskeletal:
____Joint Pain
____Joint Stiffness / Swelling
____Muscle joint / weakness
____Muscle pain/cramps
____Back Pain
____Cold extremities
____Difficulty Walking

Endocrine:
____Skin Becoming Dryer
____Excessive Thirst
____Heat / Cold Intolerance

Psychiatric:
____Memory Loss/Confusion
____Nervousness
____Depression
____Insomnia

Neurological:
____Frequent/recurring headaches
____Light headed / dizzy
____Convulsions / Seizures
____Numbness / Tingling Sensations
____Tremors
____Paralysis
____Head Injury

Psychiatric:
____Memory Loss / Confusion
____Nervousness
____Depression
____Insomnia

Hematological/Lymphatic:
____Slow healing
____Easy Bruising / Bleeding
____Enlarged Glands

Authorization: Benefits to Physician

☐Yes ☐No I hereby authorize payments directly to Athens Podiatry PC of surgical and/or medical benefits.

☐Yes ☐No I also understand that I am responsible for any portion of my bill NOT covered by the insurance company.

☐Yes ☐No I authorize the release of information for insurance claim purposes. This information may contain medical information pertaining to communicable or venereal disease, including gonorrhea, HIV and AIDS.

☐Yes ☐No I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

PRINT Name:	Signature:	Date:

Authorize release of your medical records:

Name:	Relationship:

Name:	Relationship:

Name:	Relationship:

I certify that the information of this patient information form is correct to the best of my knowledge. I will not hold the doctor or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I give permission to the doctor/staff to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my foot, ankle and leg.

Patient Signature:	Parent authorized Rep:	Date: