COLLIER PODIATRY, P.A.

WELCOME TO OUR OFFICE

Please complete the following: (Please Print) Today's Date_____

Last Name:					**First Name:**					**M:**
Marital Status:	S	M	D	W	Name of Spouse:				Date of Birth:	
Race: (Circle One)	Caucasian	African American	Asian	Hispanic/ Latino	Other:	Ethnicity: (Circle One)	Hispanic/ Latino	NOT Hispanic / Latino		
Height:		Weight:			Shoe Size:	**Gender:** (Circle One)	**Female**	**Male**		
Home Phone:			Work:			**Mobile:**				
State of Primary Residence					**E-Mail Address:**					

Local Address:		
City:	**State:**	**Zip**:

Second or Out-of-State Address:		
City:	State:	Zip:

Pharmacy:	**Pharmacy Phone:**
Pharmacy Address or Intersection:	

Retired:	☐	Employed:	☐	Employer:		Employer Phone:	

Name of Emergency Contact:	Relationship:
Emergency Contact Phone Number:	

Name of Primary Care Physician:		**Date Last Seen:**
Phone:	Fax:	Address:

COLLIER PODIATRY, P.A.

REVIEW OF SYSTEMS:

● Please circle Yes or NO for each item ●

General Symptoms:				**Throat/Neck:**		
Chills	Yes	No		Hoarseness	Yes	No
Weakness	Yes	No		Tenderness	Yes	No
Fatigue	Yes	No		Lumps	Yes	No
Weight Gain	Yes	No		Sore Throat	Yes	No
Fever	Yes	No				
Weight Loss	Yes	No		**Respiratory:**		
				Asthma	Yes	No
Head:				Cough	Yes	No
Dizziness	Yes	No		Tuberculosis/ T.B.	Yes	No
Pain	Yes	No		Bronchitis	Yes	No
Fainting	Yes	No		Pleurisy	Yes	No
Sweats	Yes	No		Wheezing	Yes	No
Headaches	Yes	No		C.O.P.D.	Yes	No
				Short of Breath	Yes	No
Nose:						
Bleeding	Yes	No		**Cardiovascular:**		
Obstruction	Yes	No		Chest Pain	Yes	No
Discharge	Yes	No		Hair Loss on Legs	Yes	No
Infection	Yes	No		History of MI	Yes	No
				Replacement Heart Valve	Yes	No
Mouth:				Vascular Grafts	Yes	No
Bleeding	Yes	No		Cramps in Legs/Feet	Yes	No
Post Nasal Drip	Yes	No		Heart Murmur	Yes	No
Dentures	Yes	No		Leg or Foot Ulcers	Yes	No
Dry Mouth	Yes	No		Rheumatic Fever	Yes	No
				Extremity(s) Cool	Yes	No
Ears:				High Blood Pressure	Yes	No
Hearing Aid	Yes	No		Palpations	Yes	No
Infections	Yes	No		Varicose Veins	Yes	No
Ringing	Yes	No				
				Musculoskeletal:		
Gastrointestinal:				Ankle Sprain	Yes	No
Antacid Use	Yes	No		Back Problems	Yes	No
Excessive Thirst	Yes	No		Bunions	Yes	No
Hemorrhoids	Yes	No		Corns	Yes	No

COLLIER PODIATRY, P.A.

Gastrointestinal *continued:*				**Musculoskeletal *continued:***		
Jaundice	Yes	No		Gout	Yes	No
Nausea	Yes	No		High Arch Feet	Yes	No
Constipation	Yes	No		Joint Pain	Yes	No
Gall Bladder Disease	Yes	No		Lower Back Pain	Yes	No
Hepatitis	Yes	No		Neuroma	Yes	No
Laxatives	Yes	No		Restricted Motion	Yes	No
Rectal Bleeding	Yes	No		Weakness	Yes	No
Diarrhea	Yes	No		Arch Pain	Yes	No
Heart Burn	Yes	No		Broken Ankle	Yes	No
Hiatal Hernia	Yes	No		Calluses	Yes	No
Liver Disease	Yes	No		Flat Feet	Yes	No
Swallowing Problem	Yes	No		Hammer/Mallet Toes	Yes	No
				In-Toeing	Yes	No
Psychiatric:				Joint Stiffness	Yes	No
Depression	Yes	No		Muscle Cramps	Yes	No
Disorientation	Yes	No		Orthotic Use	Yes	No
Memory Loss	Yes	No		Shoe Insert Use	Yes	No
				Arthritis	Yes	No
Integumentary (Skin):				Broken Foot Bone	Yes	No
Athlete's Foot	Yes	No		Childhood Foot Problems	Yes	No
Fungal Nails	Yes	No		Gait (Walking) Problems	Yes	No
Itching	Yes	No		Heel Pain	Yes	No
Mole Changes	Yes	No		Joint Implants	Yes	No
Dryness	Yes	No		Knee Pain	Yes	No
Hives	Yes	No		Muscle Stiffness	Yes	No
Keloid Scar	Yes	No		Paralysis	Yes	No
Rash	Yes	No		Toe Walking	Yes	No
Eczema	Yes	No				
Ingrown Nails	Yes	No		**Endocrine:**		
Lumps	Yes	No		Fatigue	Yes	No
Warts	Yes	No		Thirst	Yes	No
Swallowing Problem	Yes	No		Weight Loss	Yes	No
				Goiter	Yes	No
Neurological:				Thyroid	Yes	No
Black Outs	Yes	No		Sweats	Yes	No
Fainting	Yes	No		Weight Gain	Yes	No
Speech Disorders	Yes	No		Diabetic	Yes	No
Tremors	Yes	No		Most Recent A1C & Date	Yes	No
Burning	Yes	No				

COLLIER PODIATRY, P.A.

***Neurological** continued*:				**Hematological / Lymphatic:**		
Neuromas	Yes	No		Anemia	Yes	No
Strokes	Yes	No		Easily Bruised	Yes	No
Unsteady Gait	Yes	No		Swollen Glands	Yes	No
Charcot Neuroarthropathy	Yes	No		Bleeding Easily	Yes	No
Numbness	Yes	No		Recent Chemotherapy	Yes	No
Tingling	Yes	No		Transfusion Reaction	Yes	No
Neuropathy	Yes	No		Blood Clots	Yes	No
				Slow Healing Cuts	Yes	No
Allergic/Immunologic:						
Hives	Yes	No		**Eye:**		
Runny Nose	Yes	No		Blurred Vision	Yes	No
Swelling	Yes	No		Eye Glasses	Yes	No
Itchy Eyes	Yes	No		Cataracts	Yes	No
Sneezing	Yes	No		Glaucoma	Yes	No
Watery Eyes	Yes	No		Contacts	Yes	No
Itchy Nose	Yes	No		Infections	Yes	No
Stuffy Nose	Yes	No				
Wheezing	Yes	No				

Drug Allergies: *Please List Below*		**Medications:** *Please List Below*
☐ ***Please Check if List Attached***		☐ ***Please Check if List Attached***
☐ ***Please Check if NONE***		☐ ***Please Check if NONE***

Immunizations: *Please Provide Most Recent Date of the Following:*

Pneumonia	Date:		Influenza/ Flu	Date:	
Other:	Date:		Other:	Date:	

Medical History:

Please circle **YES** or **NO** have ever been treated for any of the following:

Anemia	Yes	No		Arthritis	Yes	No
Back Problem	Yes	No		COPD	Yes	No
High Cholesterol	Yes	No		Depression	Yes	No
Diabetes	Yes	No		GERD	Yes	No

COLLIER PODIATRY, P.A.

Medical History *continued*:						
Gout	Yes	No		Headache	Yes	No
Hepatitis	Yes	No		Hypertension	Yes	No
Irregular Heart Beat	Yes	No		MVP- Mitral Valve	Yes	No
Osteoporosis	Yes	No		Prostate Disease	Yes	No
Renal Stone	Yes	No		Skin Cancer	Yes	No
Tuberculosis/ T.B.	Yes	No		Ulcer (GI)	Yes	No
Anxiety	Yes	No		Asthma	Yes	No
Breast Cancer	Yes	No		Cancer	Yes	No
Dementia	Yes	No		Dermatitis	Yes	No
Epilepsy	Yes	No		Glaucoma	Yes	No
HIV	Yes	No		Heel Pain	Yes	No
Hip Pain	Yes	No		Hysterectomy	Yes	No
Leg Cramps	Yes	No		Migraine	Yes	No
Pneumonia	Yes	No		Psoriasis	Yes	No
Restless Leg Syndrome	Yes	No		Stroke	Yes	No
Thyroid Disease	Yes	No		Other:		

Surgeries:		*Please check box if applicable*					
AAA Repair		Aortic Aneurysm		Appendectomy		Breast Augmentation	
Breast Reduction		CABG		Carotid Endarterectomy		Cataract Extraction	
Cesarean Section		Cholecystectomy		Colectomy		Duodenal Ulcer	
ESWL		Ectopic Pregnancy		Fracture		Gall Bladder	
Gastric Banding		Heart Valve		Abdominal Hernia		Hip Fracture	
Hip Surgery		Hysterectomy		Intestinal By-Pass		Knee Arthroscopy	
Knee Surgery		LS Spine Surgery		Lasik		Mastectomy	
Oophorectomy (Ovary Removal)		PTCA		PVD Procedure		Pacemaker	
Prior Surgeries		Prostate Biopsy		Prostatectomy Retro		Arthroscopy	
Shoulder Surgery		Sinusectomy (Nasal)		Splenectomy		TURP	
Thyroidectomy		Tonsillectomy		Tubal Ligation		Vasectomy	
Other:							

COLLIER PODIATRY, P.A.

Social History:

Check box if a Non-Smoker: ☐ **Check box if a Non-Drinker:** ☐

Tobacco Use	Date Last Used	Daily Usage	Alcohol Use	Date Last Used	Daily Usage
Cigarettes			Beer		
Cigars			Wine		
Pipe			Hard Liquor		
Chewing Tobacco					
Dipping Tobacco					

Please Read the Following Statements and Circle the Appropriate Response:

Have you ever felt you should cut down on your drinking?	Yes	No
Have people annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of	Yes	No

Family History: (First Degree Relatives)

Please circle **YES** or **NO** if anyone in your ***immediate*** family has ever been treated for any of the following:

Anemia	Yes	No		Arthritis	Yes	No
Back Problem	Yes	No		Cancer	Yes	No
Dementia	Yes	No		Dermatitis	Yes	No
Emphysema	Yes	No		G.E.R.D.	Yes	No
Gout	Yes	No		Headache	Yes	No
Hepatitis	Yes	No		Irregular Heart Beat	Yes	No
Lung Cancer	Yes	No		Migraine	Yes	No
Pneumonia	Yes	No		Restless Leg Syndrome	Yes	No
Tuberculosis/ T.B.	Yes	No		Ulcer (GI)	Yes	No
Anxiety	Yes	No		Asthma	Yes	No
COPD	Yes	No		High Cholesterol	Yes	No
Depression	Yes	No		Diabetes	Yes	No
Epilepsy	Yes	No		Glaucoma	Yes	No
HIV	Yes	No		Heart Disease	Yes	No
Hypertension	Yes	No		Leg Cramps	Yes	No
MVP- Mitral Valve Prolapse	Yes	No		Osteoporosis	Yes	No
Renal Stone	Yes	No		Stroke	Yes	No
Thyroid Disease	Yes	No		Other:		

COLLIER PODIATRY, P.A.

Family History *continued*:			
RELATIVE	AGE	LIVING/DECEASED	SERIOUS ILLNESS/ CAUSE OF DEATH
Mother			
Father			
Siblings			
Children			

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to read (if I so chose to), and, to understand the Notice of Privacy Practices, as posted in the office.

Insurance Information

○ I have no insurance. ○ I have insurance. ○ I have Medicare.

Your Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Policy Holder Name: _____ Date of Birth: _____

MEDICAL RELEASE

I consent to diagnosis and treatment of my medical condition (or of a minor) by the staff of Collier Podiatry, P.A. I authorize release of information necessary to process any claim to my insurance company. I also agree that any balance not covered by my insurance company will be paid for by myself. I agree to notify this office of any changes of my insurance status and/or changes in coverages immediately. I agree that photocopies of this form will be as valid as the original.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled due under my insurance policy for the amount to satisfy the fees for services rendered by Collier Podiatry, P.A. I understand I am financially responsible for all charges, whether or not paid by my insurance company. I also agree that any payments made to me by my insurance company for services rendered by Collier Podiatry, P.A. will immediately be forwarded to this office.

Patient Name (Please Print)	Signature	Date