

FOOT & ANKLE ASSOCIATES, LTD.  
4650 SOUTHWEST HIGHWAY, OAK LAWN, IL 60453

PATIENT INFORMATION FORM  
(PLEASE PRINT)

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_

PATIENT NAME: \_\_\_\_\_ SEX: M F  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ YES NO

ALTERNATE PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ YES NO

E-MAIL: \_\_\_\_\_ YES NO

PRIMARY LANGUAGE: \_\_\_\_\_

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ WHO REFERRED YOU TO US? \_\_\_\_\_

PRIMARY CARE DOCTOR'S OFFICE ADDRESS: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

\_\_\_\_ NO \_\_\_\_ YES NAME(S) \_\_\_\_\_

WHO IS RESPONSIBLE FOR PAYMENT? \_\_\_\_\_ RELATIONSHIP TO PATIENT? \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

**SOCIAL HISTORY**

MARITAL STATUS:  SINGLE  MARRIED  PARTNERED  SEPARATED  DIVORCED  WIDOWED  
NAME OF SPOUSE, IF APPLICABLE: \_\_\_\_\_

USE OF ALCOHOL:  NEVER  NO LONGER USE  HISTORY OF ALCOHOL ABUSE  
 CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

USE OF TOBACCO:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_  SMOKE \_\_\_\_\_ PACKS/DAY FOR \_\_\_\_\_ YEARS

USE OF RECREATIONAL DRUGS:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_  
 CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW MUCH ARE YOU ON YOUR FEET AT WORK?  10%  25%  50%  75%  100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE?  CHILDREN-AGE(S) \_\_\_\_\_  PET(S)-WHAT KIND? \_\_\_\_\_  
 ELDERLY OR DISABLED FAMILY MEMBER  OTHER \_\_\_\_\_

EXERCISE:  NEVER  RARE  OCCASIONAL  WEEKLY  SEVERAL TIMES A WEEK  DAILY

TYPES OF EXERCISE: \_\_\_\_\_

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF:  DIABETES  CANCER  HEART DISEASE  HIGH BLOOD PRESSURE  
 STROKE  CORONARY ARTERY DISEASE  THYROID DISEASE  RHEUMATOID ARTHRITIS  
 OTHER \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

YOUR MEDICAL HISTORY

ALLERGIES:  NONE KNOWN  MEDICATIONS \_\_\_\_\_  
 ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_  
 TAPE  LATEX  SHELLFISH  IODINE  OTHER \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y N	FIBROMYALGIA	Y N	NEUROPATHY	Y N
ANEMIA	Y N	GOUT	Y N	OPEN SORES	Y N
ARTHRITIS	Y N	HEART ATTACK	Y N	PNEUMONIA	Y N
ASTHMA	Y N	HEART DISEASE/FAILURE	Y N	POLIO	Y N
BACK TROUBLE	Y N	HEPATITIS	Y N	RHEUMATIC FEVER	Y N
BLADDER INFECTIONS	Y N	HIV+/AIDS	Y N	SICKLE CELL DISEASE	Y N
ABNORMAL BLEEDING	Y N	HIGH BLOOD PRESSURE	Y N	SKIN DISORDER	Y N
BLOOD CLOTS	Y N	KIDNEY DISEASE	Y N	SLEEP APNEA	Y N
BLOOD TRANSFUSION	Y N	LIVER DISEASE	Y N	STOMACH ULCERS	Y N
BRONCHITIS/EMPHYSEMA	Y N	LOW BLOOD PRESSURE	Y N	STROKE	Y N
CANCER	Y N	MIGRAINE HEADACHES	Y N	THYROID DISEASE	Y N
DIABETES	Y N	MITRAL VALVE PROLAPSE	Y N	TUBERCULOSIS	Y N

OTHER CONDITIONS: \_\_\_\_\_

WOMEN: ARE YOU PREGNANT YES NO IF SO, HOW MANY MONTHS? \_\_\_\_\_

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



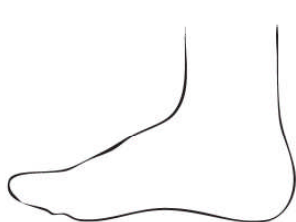
TOP OF FOOT



BOTTOM OF FOOT



INSIDE OF FOOT



OUTSIDE OF FOOT

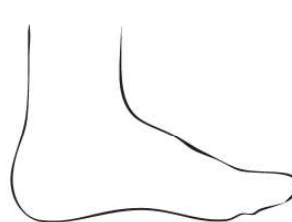
RIGHT FOOT



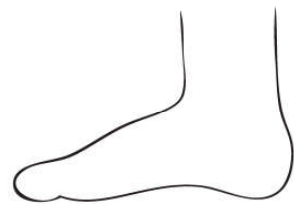
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN?  NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER \_\_\_\_\_

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)  
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:  STAYED THE SAME  BECOME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES  
 RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES (DESCRIBE) \_\_\_\_\_  No

IF YES, WAS IT A WORK-RELATED INJURY?  Yes  No

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I HEREBY AUTHORIZE FOOT & ANKLE ASSOCIATES, LTD. TO TREAT ME IN ANY WAY THAT IS APPROPRIATE AND TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT. TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME AND MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY MEDICAL BILLS NOT PAID BY MY INSURANCE CARRIER.

\_\_\_\_\_  
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
SIGNATURE OF DOCTOR

\_\_\_\_\_  
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE