Patient Name:_____ DOB:_____

Health History Intake Form

The federal government has defined a complete electronic medical record (EMR) or electronic health record (EHR) as containing four basic functions: computerized orders for prescriptions, computerized orders for tests, reporting of test results, and physician notes.

In 2009, as a part of the Economic Stimulus, the federal government began offering incentives to providers to encourage implementation of electronic health records.

Providers must attest to demonstrating "meaningful use" **every year** to avoid payment adjustment. Providers have to show that they are "meaningfully using" their EHRs by meeting thresholds for a number of objectives.

As part of the objectives we are asked to have our patients complete medical history questions, and demographics so that we may eventually qualify for "meaningful use".

Thank you for your cooperation in completing this information**.**

***Email Address:** _____

Smoking Status

(Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

If yes, what is your level of interest in quitting smoking? **(Circle): Not interested Interested**

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American /

White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Current Medical Concern:

Please describe your foot/ankle problem (include date of injury if applicable)

_____

_____

Which Side: ☐ Left ☐ Right ☐ Both Location: ☐Ankle ☐Foot ☐Toes_____

How long has the problem been present?_____

Please characterize the pain: ☐ Sharp ☐ Dull ☐ Ache ☐Throbbing ☐Bruise ☐No

Have you had any treatment or taken anything for it?_____

Have you seen someone for this already? __No __Yes Whom?_____

Patient Name:_____ DOB:_____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medications: (Please enter all current medications, or attach legible list)

_____

_____

_____

Allergies to Medications: (Please enter all drug allergies)

_____

_____

_____

_____

ALERTS: (please ☑ all that apply)

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy
- ☐ History of blood transfusions

Past Medical History: (please ☑ all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None of the above

Other _____

Patient Name:_____ **DOB:**_____

Past Surgical History: (please ☑ all that apply)

- ☐ Appendix Removed(Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Mastectomy (☐Right ☐Left ☐Both)
- ☐ Lumpectomy (☐Right ☐Left ☐Both)
- ☐ Breast Biopsy(☐Right ☐Left ☐Both)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Percutaneous transluminal coronary angioplasty (ptca)
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement Knee (☐Right ☐Left ☐Both)
- ☐ Joint Replacement Hip (☐Right ☐Left ☐Both)
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Nephrectomy) (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed (splenectomy)
- ☐ Testicles Removed (Right, Left, Both)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ None of the above

Other:_____

Foot and Ankle Conditions History: (please ☑ all that apply)

- ☐ Achilles Pain
- ☐ Ankle Instability
- ☐ Ankle Sprain
- ☐ Arch Pain
- ☐ Arthritis Location:_____
- ☐ Arch Pain
- ☐ Athlete's Foot
- ☐ Ball of Foot Pain
- ☐ Bunions
- ☐ Bursitis
- ☐ Calf Pain
- ☐ Callus
- ☐ Custom Orthotics
- ☐ Dermatitis
- ☐ Diabetic Foot Care
- ☐ Diabetic Neuropathy
- ☐ Diabetic Vascular Disease
- ☐ Dry Skin
- ☐ DVT
- ☐ Edema
- ☐ Flat Feet
- ☐ Fracture - Toe
- ☐ Fungus Nails
- ☐ Ganglion Cyst
- ☐ Gout
- ☐ Hammertoes
- ☐ Heel Pain
- ☐ Infection
- ☐ Ingrown Nail
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Nerve Impingement
- ☐ Neuroma
- ☐ Plantar Fasciitis
- ☐ Shin Splints
- ☐ Ulcer/Wound
- ☐ Vericose Veins
- ☐ Warts

Other:_____

Patient Name:_____ DOB:_____

Family History: (please ☑ all that apply)
Relative with the following (A - Alive / D- Deceased)

Mother A / D	**Father A / D**	**Siblings A / D**	**Children A / D**
☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis
☐ Asthma/Emphysema	☐ Asthma/Emphysema	☐ Asthma/Emphysema	☐ Asthma/Emphysema
☐ Cancer_____	☐ Cancer_____	☐ Cancer_____	☐ Cancer_____
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Gout	☐ Gout	☐ Gout	☐ Gout
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease	☐ Kidney Disease
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Tuberculosis	☐ Tuberculosis	☐ Tuberculosis	☐ Tuberculosis
☐ Mal. Hyperthermia	☐ Mal. Hyperthermia	☐ Mal. Hyperthermia	☐ Mal. Hyperthermia
☐ HIV/AIDS	☐ HIV/AIDS	☐ HIV/AIDS	☐ HIV/AIDS
☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure
☐ Other	☐ Other	☐ Other	☐ Other

Review of Systems: (Please ☑ Yes/No for the following) **Symptom)** Are you **currently** experiencing any of the following?

- ☐ **Problem with bleeding**
- ☐ **Problems with healing**
- ☐ **Rash**
- ☐ **Immunosuppression**
- ☐ **Hay fever**
- ☐ **Chest pain**
- ☐ **Fever or chills**
- ☐ **Night sweats**
- ☐ **Unintentional weight loss**
- ☐ **Thyroid problems**
- ☐ **Sore throat**
- ☐ **Blurry vision**
- ☐ **Abdominal pain**
- ☐ **Bloody stool**
- ☐ **Bloody urine**
- ☐ **Joint aches**
- ☐ **Muscle Weakness**
- ☐ **Neck stiffness**
- ☐ **Headaches**
- ☐ **Seizures**
- ☐ **Cough**
- ☐ **Shortness of breath**
- ☐ **Wheezing**
- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Depression**

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

**If not patient, relationship to patient:

___Parent ___Power of attorney ___Legal Guardian ___ Other:_____