

**CAROLINA FOOT & ANKLE ASSOCIATES, PLLC  
ANNUAL UPDATE**

**Patient Name:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_

**Referring Physician (Name & Practice Location):** \_\_\_\_\_

**Preferred Pharmacy & Location:** \_\_\_\_\_

**1. Describe your foot/ankle problem(s) (including left, right or both) :**

\_\_\_\_\_  
\_\_\_\_\_

**2. How long have you had this problem?** \_\_\_\_\_

**3. Are you experiencing pain?**  No  Yes (if yes, please answer the following)

How long have you had pain? \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

Describe the type of foot pain:  Burning  Aching  Sharp  Stabbing  Throbbing  Pins/Needles  Numb

Pain severity 0 = none, 10 = very severe (please circle) 0 1 2 3 4 5 6 7 8 9 10

Exact location (if possible): \_\_\_\_\_

How frequent is the pain?  Constant  Daily  Often  Occasionally  Rarely

Pain is often experienced with:  Walking/Standing  Resting  Certain Shoes  Pressure  With Activity

The pain is made worse by: \_\_\_\_\_

Do you feel numbness in your feet?  Yes  No      Tingling?  Yes  No

**Social History**

**4. If female, are you currently pregnant?**  No  Yes  Maybe

**5. Do you smoke cigarettes?**  No  Yes If so, for how many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

**6. Are you a former smoker?**  No  Yes If so, for how many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

**7. If you have diabetes, please answer the following questions:**

Do you check your blood sugar at home?  Yes  No If so, how often? \_\_\_\_\_ Last result: \_\_\_\_\_

Last Hemoglobin A1C Value: \_\_\_\_\_ Date: \_\_\_\_\_ Drawn where? \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES**

CAROLINA FOOT & ANKLE ASSOCIATES, PLLC

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8. Have you had any surgeries or hospitalizations in the past two years?  No  Yes

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Allergies (If yes, what type of reaction?)  NONE  Latex \_\_\_\_\_

Penicillin \_\_\_\_\_  Sulfa Drugs \_\_\_\_\_

Other Antibiotics (which ones?) \_\_\_\_\_  Nickel/Other Metals \_\_\_\_\_

Aspirin \_\_\_\_\_  Surgical Implants \_\_\_\_\_

NSAIDS (Ibuprofen/Aleve): \_\_\_\_\_  X-ray Contrast Dye \_\_\_\_\_

Pain Medication (which ones?): \_\_\_\_\_  Other \_\_\_\_\_

10. List all Medications/vitamins with dose & directions:  NONE  I have attached a list

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Do you take the following?  Tylenol  Advil, Ibuprofen, Aleve or Motrin

If so, how much? \_\_\_\_\_ How often? \_\_\_\_\_

12. Vaccines Have you had a Flu Vaccine?  Yes  No If Yes, approximately when? \_\_\_\_\_

Have you had a Pneumonia Vaccine?  Yes  No If Yes, approximately when? \_\_\_\_\_

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13. **Family History** (Who in your family has had these medical problems?):

NONE

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes _____              | <input type="checkbox"/> Heart Disease _____     | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Hypertension _____          | <input type="checkbox"/> Stroke _____            | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Arthritis _____             | <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Cancer _____         |
| <input type="checkbox"/> Other Family History: _____ |  |   |

14. **VITAMIN D LEVEL** Have you had your Vitamin D Level checked?  Yes (  normal  abnormal)  No  Unsure

15. **Past Medical History:** (Check those that apply to you)  NONE

<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Other Cancer (where?)	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> GERD
<input type="checkbox"/> Lung/Respiratory Disorders	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Past Heart Attack (when?)	Do you receive kidney dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	# Years:
<input type="checkbox"/> History of Blood Clots	<input type="checkbox"/> Gout
<input type="checkbox"/> Other Bleeding Disorders	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Other Arthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Depression or Mood Swings	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Neuropathy or Nerve Damage	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other:	<input type="checkbox"/> History of MRSA Infection

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.

**Signature:**   X   \_\_\_\_\_  
Patient or Personal Representative

**Date:** \_\_\_\_\_

To be used by Carolina Foot & Ankle Staff:

BP (sitting): \_\_\_\_\_/\_\_\_\_\_  
Pulse \_\_\_\_\_/min (Reg. Irreg.)      Resp. \_\_\_\_\_/min      Temp: \_\_\_\_\_°F  
Height \_\_\_\_\_      Weight \_\_\_\_\_      If over 65, Falls? \_\_\_\_\_

**CAROLINA FOOT & ANKLE ASSOCIATES, PLLC  
DEMOGRAPHICS**

**Patient's Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle Int:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Gender:** \_\_\_\_\_ **Marital Status:**  Single  Married  Widowed  Divorced  Legally Separated

**Race:**  White  Black  Hispanic  Asian  Native American  Other: \_\_\_\_\_

**Ethnicity:**  Hispanic  Non Hispanic **Preferred language:** \_\_\_\_\_

**Social Security:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Primary Care Doctor's Practice Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**Who carries the insurance?**  The patient  Other (Name): \_\_\_\_\_ **DOB:** \_\_\_\_\_

**How did you hear about our practice?** \_\_\_\_\_

**Is the patient in a facility (ex: nursing home)?** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Responsible Party**

If someone (other than the patient) is responsible for the patient's bill, please complete the following:

**Responsible Party's Name:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**In case of emergency, whom do we contact?** \_\_\_\_\_

**Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**If you would like to update the list of people that we can talk to about your medical care or who can pick items up for you, please ask for a new HIPAA form.**

I authorize the release of any medical information necessary to process my insurance claim and request payment of benefits to the doctor. I hereby give permission to the doctor to administer treatment and to perform any minor procedures as may be needed in the diagnosis and/or treatment of my foot and ankle condition. I understand that services rendered should be paid for at the time of service unless other arrangements have been made.

I authorize payment of insurance benefits to the doctor. This authorization applies to all dates of service until revoked.

**Signature:**   X   \_\_\_\_\_

**Date:** \_\_\_\_\_

Patient or Personal Representative