Instride Queen City Foot & Ankle Specialists

Mandatory Yearly Update

First Name: _____MI____ Last:_____

Address: _____

City: _____ State: _____ Zip:_ _____

DOB: _____ Home Phone: _____ SHOE SIZE:_____

Cell Phone: _____ E-MAIL: _____

Primary Care Doctor: _____ Practice Name : _____

Emergency Contact: Name_____ Phone: _____

Past Medical History

Psoriasis Anxiety Arthritis Asthma History of Blood clots (Legs) Stroke

Sciatica Back Problems Parkinson's Disease Heart Disease Thyroid Disease

Heart Failure COPD Cancer High Cholesterol Malignant Melanoma Stomach Ulcers

Dementia/Alzheimer's Depression Diabetes (Last A1C_____)

IBS/Chron's Disease GERD (reflux) Poor Circulation Gout Kidney Disease Ulcers

HIV Hepatitis High Blood Pressure Heart Attack Migraine Varicose Veins

- **Please list your past surgeries with the date:**

_____

Social History

Are you a student? Yes, Part time Yes, Full Time No, not Currently a Student

Are you employed? Yes, Part Time Yes, Full Time No, Not Currently Employed

Employer (Company Name): _____ Occupation: _____

- Do you currently smoke or chew tobacco? Yes or No If no, have you in the past? Yes or No

How many packs per day? _____

- Do you drink alcohol, beer or wine? Yes or No If no, have you in the past? Yes or No

Family Medical History

FATHER: Deceased Diabetes Heart Disease Kidney Disease Cancer Arthritis High BP

MOTHER: Deceased Diabetes Heart Disease Kidney Disease Cancer Arthritis High BP

Current Symptom Review:

Decrease in strength muscle weakness back pain knee joint pain joint pain in toes

Muscle aches arthralgias limb swelling stiffness of joints difficulty walking not itching peeling skin rash skin wound discoloration of nails Chest pain palpitations leg pain with exercise limb swelling varicose veins Dry Skin

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List any exercises or athletic activities:

_____

Reason for your visit:

_____

Percentage of waking hours you spend on your feet (circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Do you have (Please circle) Artificial Joints, Replacement heart valves, or other implants?

Medication History

- Please list **all medications, herbal supplements, and over the counter medications** that you are currently taking:

_____

_____

_____

_____

_____

_____

- Please list any drug **allergies** you have and the reaction you experienced:

_____

_____

Pharmacy Name: _____

City & Street: _____ Phone Number: _____

****PLEASE ALLOW UP TO 2 HOURS BEFORE GOING TO PHARMACY TO PICK UP MEDICATION AS WE SEND ALL PRESCRIPTIONS ELECTRONICALLY****

Are you sensitive to Tapes or Adhesives? Yes or No

Do you have any problems taking Aspirin or Ibuprofen (Aleve, Motrin, and Advil? Yes or No

If yes, please describe:

_____

_____

Are all of your immunizations up to date? Yes or No
Have you had a current flu shot? Yes or No
Are you pregnant or breastfeeding? Yes or No

Do you have a Health Care Power of Attorney? Yes or No If yes, please provide the following information:

Name: _____ DOB: _____

Address: _____ Phone: _____

HIPPA Acknowledgement: I hereby acknowledge that I have been made aware that Queen City Foot and Ankle Specialists (QCFAS) has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and has made this policy available to me. I am entitled to a copy of the privacy policy upon request.

I authorize the release of any previous exams, results or images in the event QCFAS is in need of them to help with the diagnosis or treatment of my conditions. I understand and acknowledge that I am personally responsible for the services rendered at this facility. QCFAS will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

I authorize QCFAS (Dr. Roxanne Burgess, whomever they designate) to examine, administer treatment and to perform such general procedures as she (they) may deem necessary in the diagnosis and/or treatment of my condition(s). I further certify that to the best of my belief and knowledge the information provided on my personal health history is true, accurate and complete. I also authorize the physician designated to release information acquired in the course of my examination and treatment.

Patient or Guardian Signature X: _____

Printed Name: _____

Date: _____