Valley Foot and Ankle
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PATIENT INFORMATION FORM

Patient's Name (please print) _____ **Nickname** _____
DOB _____ **Age** _____ ☐**Male** ☐**Female** **SSN** _____ **Marital Status** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Other**
Address _____ **City** _____ **State** _____ **ZIP** _____
Email (required) _____
Home Phone _____ **Mobile Phone** _____ **Work Phone** _____
Emergency Contact _____ **Phone** _____ **Relationship** _____

MEDICAL INSURANCE INFORMATION ☐Check if Uninsured

Primary Insurance Co. _____ Name of Insured (if other than self) _____
ID Number _____ Birthdate: _____ Relationship to Patient _____
Group Number _____ Patient Is: ☐Subscriber ☐Spouse ☐Dependent

Secondary Insurance Co. _____ Name of Insured (if other than self) _____
ID Number _____ Birthdate: _____ Relationship to Patient _____
Group Number _____ Patient Is: ☐Subscriber ☐Spouse ☐Dependent

☐ Work Injury (please check) Claim (L&I) #_____ Date of Injury _____
Claim filed? ☐Yes ☐No Where was claim filed? _____ Cause of Injury _____

SOCIAL HISTORY

Occupation _____ Employer_____
Height _____ Weight _____ Shoe Size _____
Alcohol Use: ☐ None ☐ Occasional ☐ Mild/ Moderate ☐ Heavy
Do you smoke? ☐ No ☐ Yes _____ Packs/day
Recreational Drugs ☐ No ☐ Yes Type _____
Pregnant or possibly pregnant? ☐ No ☐ Yes
Exercise: ☐ None ☐ Occasional ☐ Regular Light ☐ Regular Moderate ☐ Regular Heavy

CURRENT COMPLAINT

Reason for seeing doctor today _____
Which Foot? ☐ Left ☐ Right ☐ Both Choose all that apply: ☐ Ankle ☐ Foot ☐ Toes
Duration of current condition _____ Have you had any treatments for your current condition? ☐ No ☐ Yes
If yes, explain _____

Do you wear store-bought arch supports? ☐ No ☐ Yes
Do you wear custom orthotics? ☐ No ☐ Yes If yes, who made them? _____ How old are they? _____

MEDICAL HISTORY | MENTAL/ EMOTIONAL

Have you ever had or been treated for the following?

☐ AIDS/ HIV	☐ Cancer	☐ Hepatitis/ Liver	☐ Neuropathy	☐ Seizures
☐ Arthritis - Type _____	☐ Diabetes	☐ High Blood Pressure	☐ Osteoporosis	☐ Stomach Ulcers
☐ Asthma	☐ Falling	☐ Kidney Problems	☐ Poor Circulation	☐ Stroke
☐ Back Problems	☐ Fibromyalgia	☐ Leg Cramps	☐ Problems w/ Anesthesia	☐ Thyroid Problems
☐ Bleeding Tendencies	☐ Gout	☐ Lung/ Respiratory	☐ Psoriasis	☐ Tuberculosis
☐ Blood Clots/ DVT	☐ Heart Problems	☐ Melanoma	☐ Rheumatic Fever	☐ Varicose Veins
☐ Other _____				☐ Weight Change

Please check any that apply: ☐ Eating Disorder ☐ Anxiety ☐ Depression ☐ Psychiatric ☐ Alcoholism ☐ Other _____
Current Medications _____
Are you allergic to any medications? ☐ No ☐ Yes |Please specify below|

☐ Penicillin	☐ Codeine	☐ Cortisone	☐ Anesthetics/ Novocain	☐ Latex
☐ Vicodin	☐ Demerol	☐ Aspirin	☐ Iodine/ Betadine	☐ Other _____

List surgeries, serious injuries, and illnesses_____
_____
_____

Former foot and ankle physician _____ Last visit _____
Primary Care Physician _____ Practice Name _____ Location _____
Preferred Pharmacy _____ Location _____ Phone _____

REFERRAL SOURCE

☐ Doctor _____ Location_____
☐ Patient/ Friend (please list) _____ ☐ Preferred Provider (PPO) Directory ☐ ZocDoc ☐ Google
☐ Other _____

Signature _____ **Date** _____