HEALTH HISTORY QUESTIONNAIRE

Doctor Signature _____

Patient's Full Name _____ Date _____

I prefer to be addressed as _____ Occupation _____

Medical Record Number _____ Date of Birth _____

Date Last Seen by PCP _____

Have you ever had any of the following conditions? (Check all that apply)

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer _____
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: Type I____Type II ____
  Insulin: Yes ____ No ____
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Condition
  Type _____
- ☐ Hepatitis: Type A ___ B ___ C ___
- ☐ High Blood Pressure
- ☐ Keloid/Thick Scar
- ☐ Kidney Disease
  Dialysis: Yes____ No____
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lyme Disease
- ☐ Macular Degeneration
- ☐ Nerve Disorder
- ☐ Osteoporosis
- ☐ Peripheral Artery Disease
- ☐ Phlebitis
- ☐ Psychiatric Disorder
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Venous Disease
- ☐ Other _____
- ☐ None of These

Are you slow to heal after cuts? ☐ Yes

Abnormal bruising, bleeding or scarring? ☐ Yes

Do you have vascular grafts/stents? ☐ Yes

Do you have joint implants? ☐ Yes

Do you have replacement heart valves? ☐ Yes

Do you have a pacemaker? ☐ Yes

Do you have a defibrillator? ☐ Yes

Are you under active chemotherapy? ☐ Yes

Do you have Sleep Apnea? ☐ Yes ☐ No

Do you use CPAP or BiPAP machine? ☐ Yes ☐ No

Have you had any other serious illness? ☐ Yes _____

Have you been hospitalized or been under medical care over 24 hours? ☐ Yes

Explain _____

Have you had any surgery (if yes explain below with dates)? ☐ Yes

_____

_____

_____

Did you ever smoke? ☐ Yes ☐ No Packs/Day ____Years ____

Current smoker? ☐ Yes ☐ No Packs/Day ____Years ____ Quit ___When?_____ Vape?___ E-cigarette? ___

Alcoholic Beverages? ☐ Yes ☐ No If yes, how often ____

Recreational Drugs? ☐ Yes ☐ No If yes, how often ____

Please List any Allergies (latex, penicillin, sulfa drugs, shrimp, Iodine), with reaction & severity

☐ NONE

Please List any Medication/Dose or Supplements you are taking including any over the counter medication

☐ See attached listing

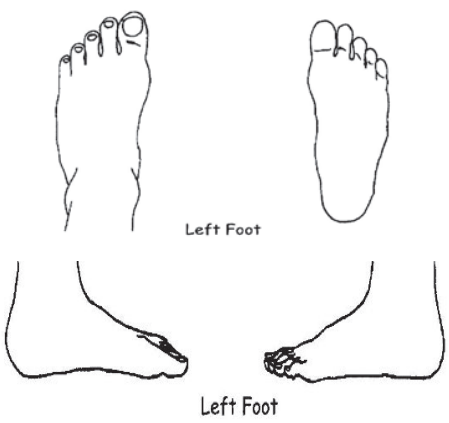
_____ _____ _____

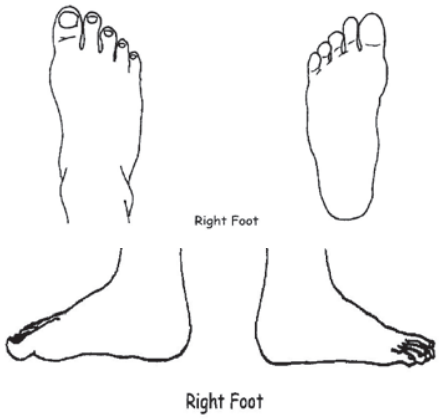
_____ _____ _____

Family Health History: Please check any that apply to your Mother, Father, Brother and/or Sister

Diabetes	M ☐	F ☐	B ☐	S ☐	Cancer	M ☐	F ☐	B ☐	S ☐
Arthritis	M ☐	F ☐	B ☐	S ☐	Heart Attack	M ☐	F ☐	B ☐	S ☐
Stroke	M ☐	F ☐	B ☐	S ☐	High Blood Pressure	M ☐	F ☐	B ☐	S ☐

Patient Signature _____





☐ Check here for Nail Care only ☐ Fungal Nails

On diagram above, please mark the location of your **First** foot problem with a **# 1**

☐ Shooting Pain ☐ Throbbing Pain ☐ Sharp Pain
☐ Burning Pain ☐ Itching ☐ Aching Pain
☐ Tenderness ☐ Dull Pain ☐ Tingling / Numbness

How long ago did the problem (pain) start? _____ days _____ weeks _____ months _____ years

Does the pain occur while walking? ☐ Yes ☐ No

Severity ☐ Light ☐ Moderate ☐ Strong

Is the problem work related? ☐ Yes ☐ No Date of Injury_____ Date reported to Employer_____

List previous medical treatments for this issue by physician or home remedies

_____

_____

On diagram above, please mark the location of your **Second** foot problem with a **# 2**

☐ Shooting Pain ☐ Throbbing Pain ☐ Sharp Pain
☐ Burning Pain ☐ Itching ☐ Aching Pain
☐ Tenderness ☐ Dull Pain ☐ Tingling / Numbness

How long ago did the problem (pain) start? _____ days _____ weeks _____ months _____ years

Does the pain occur while walking? ☐ Yes ☐ No

Severity ☐ Light ☐ Moderate ☐ Strong

Is the problem work related? ☐ Yes ☐ No Date of Injury_____ Date reported to Employer_____

List previous medical treatments for this issue by physician or home remedies

_____

_____

Have you ever been treated for or experienced any conditions of the foot and/or ankle?
(leg/foot ulcer, cramps in legs/feet, fungal nails, sprains, other)? Explain _____

_____

Shoe Size _____

Did you previously, or do you wear: Who provided them? Podiatrist ☐ Orthopedist ☐ Store ☐

Shoe Inserts ☐ Yes ☐ No Still using them ☐ Yes ☐ No Did they help ☐ Yes ☐ No
Orthotics ☐ Yes ☐ No Still using them ☐ Yes ☐ No Did they help ☐ Yes ☐ No

Are your first steps out of bed painful? ☐ Yes ☐ No Does pain subside? ☐ Yes ☐ No
Do you get leg cramps during the day? ☐ Yes ☐ No at night? ☐ Yes ☐ No

Patient Signature _____ Date _____

Doctor Signature _____

Medical Record Number _____

MEDICAL CONSENT AUTHORIZATION FOR MINORS

I, _____am the:
(name of consenting individual)

- ☐ Parent of the child listed below and there are no court orders now in effect that would prohibit me from giving consent.
- ☐ Legal guardian or legal custodian of the child by court order (copy included) and there are no other court orders in effect that would prohibit me from giving consent.

I give the following person(s) the power to consent to necessary medical treatment of (name of minor):

_____

- ☐ **I do not give any power to consent to anyone other than myself**

Delegated Individual #1:

_____ _____
(printed name) (signature)

_____
(address)

May consent to:
- ☐ Medical treatment
- ☐ In office surgical procedures

The above-mentioned Delegated Individual:
- ☐ May go into the room with my child
- ☐ May not go into the room with my child
- ☐ May have access to any/all records including, but not limited to: insurance records regarding any such services.

Delegated Individual #2:

_____ _____

(printed name) (signature)

_____

(address)

May consent to:

- ☐ Medical treatment
- ☐ In office surgical procedures

The above-mentioned Delegated Individual:

- ☐ May go into the room with my child
- ☐ May not go into the room with my child
- ☐ May have access to any/all records including, but not limited to: insurance records regarding any such services.

I confer the power of consent freely and knowingly in order to provide for the child and not as the result of pressure, threats or payments by any person or agency.

This form is in effect until the minor reaches 18 years of age. I understand I have the right to revoke or make changes to this consent should I wish to do so.

Printed Name Parent/Guardian/Custodian: _____

Parent/Guardian/Custodian Signature: _____

Date/Time: _____

Witness Printed Name: _____

Witness Signature:

_____

Date/Time: _____

MARTIN FOOT AND ANKLE

DEPENDENT REGISTRATION FORM

For Patients Under their Guardian's Health Insurance

717-757-3537 or 1-800-456-0076

www.martinfootandankle.com

Patient Information

Patient's Last Name | First Name | M.I. | Nickname

Street Address | City | State | Zip

Phone Number ( ) ☐ Home ☐ Cell | Gender ☐ Male ☐ Female ☐ Other | Date of Birth | Pharmacy

Race (check one which best applies):
☐ White ☐ Asian
☐ Black/African American ☐ Other
☐ American Indian/Alaska Native ☐ Decline/Unknown
☐ Native Hawaiian/other Pacific Islander

Ethnicity:
☐ Spanish/Hispanic Origin
☐ Not of Spanish/Hispanic Origin
☐ Declined/Unknown

Preferred Language (select one):
☐ English ☐ French ☐ Italian ☐ Korean ☐ Chinese ☐ Other _____
☐ Spanish ☐ German ☐ Japanese ☐ Vietnamese ☐ Decline/Unknown

Guardian Information

Last Name of Guardian | First Name | Relationship

Street Address

City | State | Zip

Date of Birth | Phone Number ( )

Email Address

Employer ☐ Insurance Policy Holder

Guardian Information (if second guardian)

Last Name of Guardian | First Name | Relationship

Street Address

City | State | Zip

Date of Birth | Phone Number ( )

Email Address

Employer ☐ Insurance Policy Holder

How did you hear about our offices?
☐ Internet/Social Media ☐ Billboard
☐ Friend/ Relative ☐ Radio
☐ Television
☐ Referring Physician
Name _____
☐ Other _____

In Case of Emergency

Name of nearest friend/relative not living with you in your household | Phone Number ( )

Family Physician

Name of Family Physician/General Practitioner | Address | Phone Number ( )

I hereby give my permission for all physicians of Martin Foot and Ankle to administer treatment and to perform such procedures as may be necessary for the diagnosis and/or treatment of my dependent's foot and/or ankle condition.

Signature of Patient/POA/Responsible Party | Date

AUTHORIZATION STATEMENT:
I hereby authorize the processing of the medical insurance either by electronic or manual method of MARTIN FOOT AND ANKLE. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for payment of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Payment methods are: Cash, Check or Credit Card (Debit, Visa, MasterCard, Discover, American Express, and Care Credit).

Signature of Patient/POA/Responsible Party | Date

POS Reorder # 1107636