# Bethesda Foot & Ankle Center, LLC

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## REGISTRATION FORM

(Please Print)

### PATIENT INFORMATION

Date _____Home Phone( )_____Cell Phone( )_____ Email _____

Last Name_____ First Name_____ Middle Initial____ Date of Birth ___/____/____

Street_____City_____State_____Zip_____

Social Security #_____-_____-_____Age____ Sex ❑M ❑F Marital Status_____ Primary language: _____

Ethnicity: (Circle one) _ American Indian _Asian _ Black African American _ Native Hawaiian/Pacific Islander _ White _ Hispanic

Occupation_____ Work phone( )_____

Employer_____

Pharmacy**:**_____ Address:_____ City & Zip_____ Phone # _____

In case of Emergency contact_____ Relationship_____ Phone ( )_____

### FINANCIALLY RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Relationship to patient_____ Home Phone ( )_____Cell Phone ( )_____

Last Name_____ First Name_____ Middle Initial_____ Sex ❑ M ❑ F

Street_____City_____State_____Zip_____

Social Security #_____Age_____ Date of Birth____/____/_____Marital Status_____

### INSURANCE INFORMATION (COPY OF CARD(S) REQUIRED)

Primary Insurance_____ Insured's Name_____

Secondary Insurance_____ Insured's Name_____

### HOW DID YOU HEAR ABOUT US?

☐ Doctor _____ ☐ Phone Book ☐ Friend_____ ☐ Google ☐ Website

☐ Family_____ ☐ Insurance Plan ☐ Hospital/ER_____ ☐ YELP ☐ Other_____

### FAMILY PHYSICIAN INFORMATION

**Did your Family Physician or other specialist refer you? ❑ Yes ❑ No Did you independently come for an opinion? ❑ Yes ❑ No**

**Referring/Family Physician:**_____ **Date last seen:**_____

**Address:** _____**City**_____**State**_____**Zip**_____

**Phone: (** **)**_____

# MEDICAL HISTORY

**PATIENT NAME** **BIRTH DATE** / /

What is your foot/ankle problem? _____

_____

Location? Right or Left _____

When did the problem begin? Date: _____

Describe any accident/event: _____

Is the problem work related? Yes/ No _____

First visit to a doctor for this problem? **Yes** / **No**, who?

_____

On a scale of 0-10 with 10 being worst please rate your pain today:

0 1 2 3 4 5 6 7 8 9 10

Describe any previous treatment or home remedies?

_____

_____

List any sports/activites:_____

## ALLERGIES

- ❑ Penicillin
- ❑ Sulfa
- ❑ Local Anesthetic
- ❑ Anti-inflammatory Medication
- ❑ Codeine
- ❑ Adhesive Tape
- ❑ Latex
- ❑ Iodine on Skin
- ❑ IV Radio contrast Dye
- ❑ Cortisone
- ❑ Other_____
- ❑ None_____

## REVIEW OF SYSTEMS (CIRCLE Y OR N

| | | | |
|---|---|---|---|
| Headaches | **Y / N** | Excessive Thirst | **Y / N** |
| Nausea | **Y / N** | Chest Pain | **Y / N** |
| Bloody Stool | **Y / N** | Shortness of breath | **Y / N** |
| Abdominal Pain | **Y / N** | Depression | **Y / N** |
| Pain on urination | **Y / N** | Nosebleed | **Y / N** |
| Skin Rashes | **Y / N** | Calf Pain | **Y / N** |
| Fever | **Y / N** | Healing difficulty | **Y / N** |
| Bone /Joint Pain | **Y / N** | Dizziness | **Y / N** |
| Blurred Vision | **Y / N** | Inc weight loss | **Y / N** |

## LIST OF CURRENT MEDICATIONS

❑ **NONE**

## WHAT PREVIOUS SURGERIES HAVE YOU HAD? CHECK ALL THAT APPLY AND LIST ANY OTHERS

- ❑ Hysterectomy
- ❑ Cardiac(valve, pacemaker, graft, etc)
- ❑ Implant surgery (knee, hip, etc)
- ❑ Gallbladder removed
- ❑ Vascular Leg Bypass
- ❑ Appendectomy
- ❑ Tonsillectomy
- ❑ Hernia repair
- ❑ Cosmetic
- ❑ Cancer Surgery
- ❑ Other surgeries including any FOOT/ANKLE surgery:

**Have You Ever Been Put To Sleep For Surgery?** **Yes** ☐ **No** ☐ **Complications with Anesthesia?** **Yes** ☐ **No** ☐

**Height**:_____

**Weight**:_____

**Shoe size**:_____

**Do you drink alcoholic beverages?**
- ❑ No
- ❑ Yes, socially
- ❑ Daily

# Drinks/week_____

**Do you smoke cigarettes?**
- ❑ No, never
- ❑ No, I quit
- ❑ Yes currently

Packs/Day_____ #Years_____

**Do you use "recreational" drugs?**
- ❑ No, never
- ❑ No, I quit
- ❑ Yes

WHICH ONES?

## INDICATE IF YOU OR A BLOOD RELATIVE HAS HAD OR DOES HAVE ANY OF THE FOLLOWING- CHECK ALL THAT APPLY

| | SELF | | I RELATIVE | | SELF | | I RELATIVE |
|---|---|---|---|---|---|---|---|
| Anemia | ❑ Yes | ❑ No | ❑ Family | High Blood Pressure | ❑ Yes | ❑ No | ❑ Family |
| Arthritis/Rheumatism | ❑ Yes | ❑ No | ❑ Family | High Cholesterol | ❑ Yes | ❑ No | ❑ Family |
| Asthma or Respiratory Problems | ❑ Yes | ❑ No | ❑ Family | H.I.V. Positive | ❑ Yes | ❑ No | ❑ Family |
| Birth abnormalities | ❑ Yes | ❑ No | ❑ Family | Infections (MRSA, VRE) | ❑ Yes | ❑ No | ❑ Family |
| Blood Clots or Bleeding Disorders | ❑ Yes | ❑ No | ❑ Family | Kidney Trouble | ❑ Yes | ❑ No | ❑ Family |
| Cancer or tumor | ❑ Yes | ❑ No | ❑ Family | Liver Disease | ❑ Yes | ❑ No | ❑ Family |
| Diabetes Insulin Dependent | ❑ Yes | ❑ No | ❑ Family | Neurological Disorder | ❑ Yes | ❑ No | ❑ Family |
| Diabetes Non-Insulin Dependent | ❑ Yes | ❑ No | ❑ Family | Psychiatric / Psychological Care | ❑ Yes | ❑ No | ❑ Family |
| Fibromyalgia / Reflex Sympath Dyst | ❑ Yes | ❑ No | ❑ Family | Stroke/CVA/TIA | ❑ Yes | ❑ No | ❑ Family |
| Glaucoma | ❑ Yes | ❑ No | ❑ Family | Sickle Cell Disease/Trait | ❑ Yes | ❑ No | ❑ Family |
| Heart (Surgery, Disease, Attack) | ❑ Yes | ❑ No | ❑ Family | Stomach Ulcers / Reflux | ❑ Yes | ❑ No | ❑ Family |
| Hepatitis A (Infectious B/C) | ❑ Yes | ❑ No | ❑ Family | Ulcers (Diabetic) | ❑ Yes | ❑ No | ❑ Family |

**I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any changes in my health or medication.**
**I HEREBY GIVE AUTHORIZATION FOR TREATMENT.**

**X**

**Patient/Guardian Signature** **Date**

MEDICAL HISTORY REVIEWED BY (DR. SIGNATURE): DATE