

East Bay Podiatry, PC

2485 High School Ave. Suite 222 • Concord, CA 94520 • (925) 685-3117 • Fax: (925) 685-3322
Sycamore East Medical Building

Dear Patient,

Welcome to our office! Please take a few minutes to **COMPLETELY** fill out the following forms.

Bring completed paperwork to the office. If paperwork is not completed/brought to the appointment, your wait time may be longer than usual; or we may need to reschedule.

Please bring the following to your appointment:

- Your insurance Cards
- Be prepared to pay copay/co-insurance at time of visit. We accept cash (exact change appreciated), checks, health savings cards, debit cards, and credit cards except Discover.
- Picture ID
- Complete list of medications and dosages (if not available bring a bag of your medications).
- Orthotics/inserts that you currently use or have received in the past
- Any imaging studies/ x-rays/MRI's that are relevant to problem we are addressing.
- Bring shoes that you typically wear for sports and/or work.

Sincerely,

East Bay Podiatry, PC
Medical Staff

PATIENT REGISTRATION EAST BAY PODIATRY ASSOCIATES

Last Name: _____	First Name: _____	MI: _____
Physical Address: _____	City: _____	State: _____
Home Phone: (____) _____ - _____	Work Phone: (____) _____ - _____	Cell Phone: (____) _____ - _____
Email _____		
Date of Birth: ____/____/____	Age: _____	Social Security#: _____ - _____ - _____
		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Minor
<input type="checkbox"/> Partnered for _____ years		
Race:		
<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian	<input type="checkbox"/> Alaska Native
<input type="checkbox"/> Hawaiian American	<input type="checkbox"/> White/ European American	
Ethnicity:		
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non Hispanic/Latino	
Primary Language:		
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other: _____
Employment:		
<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Employer Name _____
<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Student
Emergency Contact Name: _____		
Home Phone: (____) _____ - _____	Cell Phone: (____) _____ - _____	
Relationship:		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Parent
<input type="checkbox"/> Partner	<input type="checkbox"/> Spouse	
Primary Care Physician: _____		
Office Phone: (____) _____ - _____	Date Last Seen: ____-____-____	
Referring Information: <input type="checkbox"/> Friend <input type="checkbox"/> Insurance <input type="checkbox"/> Internet <input type="checkbox"/> Phone Book		
Referring Dr.: _____		
Referring Patient: _____		
Have you been seen in our office? <input type="checkbox"/> No <input type="checkbox"/> Yes if yes when: _____		
Are you known to us by any other name? If so, what name: _____		
Is This Visit:		
<input type="checkbox"/> Work Related	<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Liability Claim
<input type="checkbox"/> Other		
<u>A copy of the Insurance Medical Card(s) is required. (A copy will be made by our staff)</u>		
Primary Insurance: _____		Secondary Insurance _____
<u>If Insured Name is not same as above:</u>		
Relationship to Insured :		<input type="checkbox"/> Spouse <input type="checkbox"/> Child
Insured Name: _____		
Insured Date of Birth _____		Insured SSN _____

Please Complete Both Sides

PATIENT REGISTRATION EAST BAY PODIATRY ASSOCIATES

Other Physicians who are caring for you:

Cardiologist: _____

Vascular Surgeon: _____

Rheumatologist: _____

Oncologist: _____

Other: _____

Privacy Information

Which phone is best for leaving medical messages: Home Cell Work

What time of day is best for leaving medical messages: AM PM

Preferred Appointment:

Days: Flexible M T W TH F
Times: Flexible AM PM

Attest

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify East Bay Podiatric Associates immediately of any changes to the above information and annually upon the office's request.

_____/_____/_____
Patients Signature or Legal Authorized Representative **Date**

(Print Name)

Relationship: Family Self Spouse Parent Partner Other

MEDICAL HISTORY

Patient Name (please print): _____

Medical History (Check All That apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Foot Ulcerations | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> MRSA Infection |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Pain in legs/feet/toes |
| <input type="checkbox"/> Cancer Type _____ | | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinsons | |
| <input type="checkbox"/> Charcot Joint | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> RSD/Chronic Pain |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Leg Cramps/Numbness | <input type="checkbox"/> Stroke/TIA _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling in legs/feet |
| <input type="checkbox"/> diet | | |
| <input type="checkbox"/> oral | | |
| <input type="checkbox"/> insulin _____ years | | |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Varicose Veins |

Surgical History (Check All That apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Angioplasty/Stent | <input type="checkbox"/> D and C | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder Surgery | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Arterial Bypass (leg) | <input type="checkbox"/> Gastric Bypass/Lapband | <input type="checkbox"/> Neck Surgery |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Open Heart Surgery |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Prostrate Surgery |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colonoscopy/Endoscopy | <input type="checkbox"/> Kidney Removal | <input type="checkbox"/> Vein Stripping |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Kidney Stone | |

Previous Foot Procedures No Yes

- | | |
|---|--|
| <input type="checkbox"/> Amputation <u>Year</u> _____
<input type="checkbox"/> Bunion _____
<input type="checkbox"/> Hammer Toe _____ | <input type="checkbox"/> Ingrown Nail _____
<input type="checkbox"/> Neuroma _____
<input type="checkbox"/> Orthotics _____ |
|---|--|

MEDICAL HISTORY

Allergies: (Check all That Apply)

- | | | | | | |
|-------------------------------------|--|---|--|---|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Anesthetics, Local | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Eggs | <input type="checkbox"/> Demerol | <input type="checkbox"/> IV Contrast Dye | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Seafood | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other: | | |

Activities/Hobbies: (Check All That apply)

- | | | | |
|----------------------------------|-----------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Baseball | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Dancing | <input type="checkbox"/> Hiking | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Running | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Yoga | <input type="checkbox"/> Other: | |

Caffeine History

None

Less than 7 cups/wk

More than 7 cups/wk

Quit using caffeine

Alcohol History

None

Less than 7 drinks/wk

More than 7 drinks.wk

Quit using alcohol

Recreational Drug History

None

Used in past

Currently using

Treated for substance abuse

Smoking History:

Number of years smoking _____

- | | | | |
|--|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Never Smoked | <input type="checkbox"/> Former smoker | | |
| <input type="checkbox"/> Current social smoker | <input type="checkbox"/> Current everyday smoker | | |
| <input type="checkbox"/> Less than 1 pk/day | <input type="checkbox"/> 1 pk/day | <input type="checkbox"/> 2 pk/day | <input type="checkbox"/> 2+ pks/day |

Social History:

Live with: Alone Spouse Partner Family Friends Roommate
Live in a: Single story home Multi-level home Hospice Skilled nursing facility
Occupation: _____ Retired Not Employed
Job requirements: Climb stairs Lift +10lbs Sit Stand Travel Walk

Family History:

	<u>Diabetes</u>	<u>Heart Disease</u>	<u>Arthritis</u>	<u>High Blood Pressure</u>
Mother	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Father	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Brother/Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Medications (please list) or See Attached List:

Pharmacy: _____

Address: _____ Zip: _____ Phone: _____

CURRENT MEDICAL SYMPTOMS

Patient Name (please print): _____

Reason for visit: _____ Date occurred: _____
 Height: _____ ft _____ inches Weight: _____ lbs Shoe Size/Width: _____

If nail or callous care only, please skip to other side and complete !!!

Current Problem: (Check All That apply)

Location: Bottom of foot Top of foot Ankle Arch Ball of foot Calf
 Inside foot Between toes Heel Leg Toe(s) Left Foot Right Foot
 How often: Constant AM PM
 Started: Today _____ Days _____ Weeks Off and On Recurrent
 _____ Months _____ Years Other: _____

Feels like: (Check All That apply)

Aching Bruised Burning Cramping Deep Dull
 Improving Inflamed Itchy Numb Pressure
 Sharp Swollen Tender Tight Tingling
 Other: _____

Pain scale:

0 1 2 3 4 5 6 7 8 9 10
 Improving Resolving Unbearable Unchanged Worse

Caused by:

Fall Increased Activity Walking Barefoot
 Injury Running Unknown Other: _____

Feels Better with: (Check All That apply)

Compression Elevation
 Heat In Shoes Medication Rest
 Other: _____

Feels Worse with: (Check All That apply)

Increase Activity Pressure
 Running Walking
 Other: _____

Additional Pain Symptoms: Check All That apply)

None Back Pain Hip Pain Knee Pain
 Muscle spasm /cramping Numbness/Tingling Weakness
 Other: _____

Current or Recent Symptoms: Check All That apply)

None Appetite Loss Chills Excessive weight gain/loss
 Fatigue Fever Night Sweats Swelling in legs or feet
 Other: _____

CURRENT MEDICAL SYMPTOMS

Current or Recent Symptoms Continued: Check All That apply)

<p><u>Eyes:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Double Vision <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Vision Loss <input type="checkbox"/> Other: _____ </p>	<p><u>Ears, Nose and Throat:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Ear Pain <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Dizzy <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Smell Loss <input type="checkbox"/> Other: _____ </p>
<p><u>Heart:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Chest Pain <input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> Other: _____ </p>	<p><u>Respiratory:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Wheezing <input type="checkbox"/> Other: _____ </p>
<p><u>Intestinal:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other: _____ </p>	<p><u>Urinary:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Other: _____ </p>
<p><u>Skin:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Nail Lesion <input type="checkbox"/> Rash <input type="checkbox"/> Non-Healing Wound <input type="checkbox"/> Ulcer <input type="checkbox"/> Wart <input type="checkbox"/> Other: _____ </p>	<p><u>Musculoskeletal:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Soft Tissue Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Other: _____ </p>
<p><u>Neurological:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Memory Loss <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures <input type="checkbox"/> Strokes <input type="checkbox"/> Other: _____ </p>	<p><u>Psychiatric:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Anxiety <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Restless <input type="checkbox"/> Other: _____ </p>
<p><u>Endocrine:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Other: _____ </p>	<p><u>Hematological:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Other: _____ </p>
<p><u>Immunologic:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Allergies <input type="checkbox"/> HIV <input type="checkbox"/> Recurrent Infections <input type="checkbox"/> Other: _____ </p>	<p><u>Reproductive:</u></p> <p> <input type="checkbox"/> None <input type="checkbox"/> Pregnant <input type="checkbox"/> Other: _____ </p>