# East Bay Podiatry Associates

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

**Dear Patient,**

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

Bring your completed paperwork. If paperwork is not completed/brought to 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 Associates Staff

# PATIENT REGISTRATION EAST BAY PODIATRY ASSOCIATES

**Last Name:** _____ **First Name:** _____ **MI:** _____

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

**Home Phone:** (_____)_____-_____ **Work Phone:** (_____)_____-_____ **Cell Phone:** (_____)_____-_____

**Email** _____

**Date of Birth:** _____/_____/_____ **Age:** _____ **Social Security#:** _____-_____-_____ **Gender:** ☐ M ☐ F

**Marital Status**

☐ Single ☐ Married ☐ Widowed ☐ Partnered for _____years
☐ Divorced ☐ Separated ☐ Minor

**Race:** ☐ American Indian ☐ Asian ☐ Alaska Native ☐ Black/African American
☐ Hawaiian American ☐ White/ European American

**Ethnicity:** ☐ Hispanic/Latino ☐ Non Hispanic/Latino

**Primary Language:** ☐ English ☐ Spanish ☐ Other: _____

**Employment:** ☐ Full-time ☐ Part-time ☐ Employer Name
☐ Retired ☐ Unemployed ☐ Student

## Emergency Contact Name: _____

**Home Phone:** (_____)_____-_____ **Cell Phone:** (_____)_____-_____

**Relationship:** ☐ Family ☐ Friend ☐ Parent ☐ Partner ☐ Spouse

## Primary Care Physician: _____

**Office Phone:** (_____)_____-_____ **Date Last Seen:** _____-_____-_____

**Referring Information:** ☐ Friend ☐ Insurance ☐ Internet ☐ Phone Book
**Referring Dr.:** _____

**Referring Patient:**

**Have you been seen in our office?** ☐ No ☐ Yes **if yes when:** _____
**Are you known to us by any other name? If so, what name:** _____

**Is This Visit:** ☐ Work Related ☐ Auto Accident ☐ Liability Claim ☐ Other

**A copy of the Insurance Medical Card(s) is required. (A copy will be made by our staff)**

**Primary Insurance:** _____ **Secondary Insurance** _____

**If Insured Name is not same as above:**

**Relationship to Insured :** ☐ Spouse ☐ 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)

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

## Surgical History (Check All That apply)

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

## Previous Foot Procedures ☐ No ☐ Yes

| | Year | | Year |
|---|---|---|---|
| ☐ Amputation | _____ | ☐ Ingrown Nail | _____ |
| ☐ Bunion | _____ | ☐ Neuroma | _____ |
| ☐ Hammer Toe | _____ | ☐ Orthotics | _____ |

# MEDICAL HISTORY

**Allergies:** **(Check all That Apply)**

☐ None ☐ Adhesive/Tape ☐ Anesthetics, Local ☐ Aspirin ☐ Blood Thinners ☐ Codeine
☐ Dairy ☐ Eggs ☐ Demerol ☐ IV Contrast Dye ☐ Iodine ☐ Latex
☐ Penicillin ☐ Seafood ☐ Sulfa ☐ Other: _____

**Activities/Hobbies:** **(Check All That apply)**

☐ None ☐ Aerobics ☐ Baseball ☐ Basketball
☐ Cycling ☐ Dancing ☐ Hiking ☐ Golf
☐ Running ☐ Soccer ☐ Swimming ☐ Tennis
☐ Walking ☐ Yoga ☐ Other: _____

| Caffeine History | Alcohol History | Recreational Drug History |
|---|---|---|
| ☐ None | ☐ None | ☐ None |
| ☐ Less than 7 cups/wk | ☐ Less than 7 drinks/wk | ☐ Used in past |
| ☐ More than 7 cups/wk | ☐ More than 7 drinks.wk | ☐ Currently using |
| ☐ Quit using caffeine | ☐ Quit using alcohol | ☐ Treated for substance abuse |

**Smoking History:** **Number of years smoking_____**

☐ Never Smoked ☐ Former smoker
☐ Current social smoker ☐ Current everyday smoker
☐ Less than 1 pk/day ☐ 1 pk/day ☐ 2 pk/day ☐ 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:**

| | Diabetes | Heart Disease | Arthritis | High Blood Pressure |
|---|---|---|---|---|
| Mother | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Father | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Brother/Sister | ☐ Yes | ☐ Yes | ☐ Yes | ☐ 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)** | **Feels Worse with: (Check All That apply)** |
|---|---|
| ☐ Compression ☐ Elevation | ☐ Increase Activity ☐ Pressure |
| ☐ Heat ☐ In Shoes ☐ Medication ☐ Rest | ☐ Running ☐ Walking |
| ☐ Other: _____ | ☐ 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)

### Eyes:
☐ None ☐ Double Vision ☐ Dry Eyes
☐ Pain ☐ Redness ☐ Vision Loss
☐ Other:_____

### Ears, Nose and Throat:
☐ None ☐ Ear Pain ☐ Ear Ringing ☐ Dizzy
☐ Hearing Loss ☐ Hoarseness ☐ Smell Loss
☐ Other:_____

### Heart:
☐ None ☐ Chest Pain ☐ Rapid Heart Rate
☐ Other:_____

### Respiratory:
☐ None ☐ Cough ☐ Shortness of Breath
☐ Snoring ☐ Sleep Apnea ☐ Wheezing
☐ Other:_____

### Intestinal:
☐ None ☐ Abdominal Pain ☐ Bloating
☐ Gas ☐ Constipation ☐ Diarrhea
☐ Nausea ☐ Vomiting ☐ Other:_____

### Urinary:
☐ None ☐ Blood in Urine
☐ Urinary Incontinence
☐ Other:_____

### Skin:
☐ None ☐ Nail Lesion ☐ Rash
☐ Non-Healing Wound ☐ Ulcer
☐ Wart ☐ Other:_____

### Musculoskeletal:
☐ None ☐ Artificial Joints
☐ Soft Tissue Pain ☐ Weakness
☐ Other:_____

### Neurological:
☐ None ☐ Memory Loss ☐ Migraines
☐ Numbness ☐ Paralysis ☐ Seizures
☐ Strokes ☐ Other:_____

### Psychiatric:
☐ None ☐ Anxiety ☐ Claustrophobia
☐ Depression ☐ Hallucinations ☐ Restless
☐ Other:_____

### Endocrine:
☐ None ☐ Cold Intolerance ☐ Diabetes
☐ Excessive Thirst ☐ Excessive Urination
☐ Heat Intolerance ☐ Other:_____

### Hematological:
☐ None ☐ Anemia ☐ Blood Transfusions
☐ Easy Bruising ☐ Prolonged Bleeding
☐ Other:_____

### Immunologic:
☐ None ☐ Allergies ☐ HIV
☐ Recurrent Infections
☐ Other:_____

### Reproductive:
☐ None ☐ Pregnant
☐ Other:_____