MORGAN HILL FOOT AND ANKLE CENTER
16360 MONTEREY ROAD SUITE 270
MORGAN HILL CA 95037
PATIENT REGISTRATION

Today's Date:	**Primary Care Physician:**

PATIENT INFORMATION

Patient's Last Name:	**First Name:**	**Middle Initial:**	**Title:**	**Birth Date:**	**Age:**	**Sex:**

PATIENT HISTORY

Reason for Visit

What brings you to the office today?

If this was an accident or injury:

Where did it occur?

Was this work related?

When did it occur?

How did it occur?

Please describe any previous treatment and care you have received for this problem.

Have you ever seen a podiatrist for this or any other problem? Please Explain.

Vitals / Pain Assessment / Podiatric History

Height_____Weight____ Last Known Blood Pressure______ Shoe Size ______

Indicate your level of pain on a scale of 1-10.

(10 = work pain imaginable)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Check the symptoms that best describe your problem.

☐Sharp Pain ☐ Dull Pain ☐Stiffness ☐Instability ☐Swelling

☐Numbness ☐ Other:_______________

Are your symptoms getting:

☐Better Gradually ☐ Better Rapidly

☐Worse Gradually ☐Worse Gradually

What improves your symptoms?

☐Ice ☐Rest ☐ Heat ☐Pain Medication

☐Other:___________________

Does your foot pain limit your desired activity?

☐Yes ☐No

Have you ever had any other foot problems?

☐Yes ☐No

If so, please explain:____

Allergies

Are you allergic to any of the following? ☐IHave No Known Allergies

☐Penicillin ☐Sulfa ☐Erythromycin ☐Aspirin

☐ Contrast dye ☐Shellfish ☐Iodine ☐Latex

☐ Anti-inflammatories (NSAIDS) ☐ Local Anesthetics (Novacaine)

☐ Nickel / Metal ☐ Lactose ☐ Egg White ☐Adhesive tape

☐ Other: ____

Explain reaction to each:

Medications

Are you currently taking any blood thinners?

☐Yes ☐No Name:____

What medications are you currently taking? (Please include over the counter and herbal medications and vitamins)

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Past Medical History

Have you ever had any of the following?

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis / Joint Disorder
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Back Problems
- ☐ Blood/ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes (Circle I **OR** II)
- ☐ Depression
- ☐ DVT (Blood Clot)
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis (Circle A /B/ C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immune Disorder
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Neuropathy
- ☐ Open Sores
- ☐ Osteoporosis/penia
- ☐ Peripheral Vascular Disease
- ☐ Polio
- ☐ Restless Leg Syndrome
- ☐ RSD (Reflex Sympathetic Dystrophy
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Stomach Ulcer / GERD / Acid Reflux
- ☐ Thyroid Disorder
- ☐ Tuberculosis

Please further explain all of the above marked condition or any other conditions you have that are not listed above:

____

____

____

Woman Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

Hospitalizations & Surgeries

Reason	Date
____________________	__________
____________________	__________
____________________	__________
____________________	__________
____________________	__________
____________________	__________
____________________	__________
____________________	__________

Review of Systems

Please mark all that apply:

General: ☐ Weight Gain/Loss ☐ Change in Appetite ☐ Fever ☐ Chills ☐ Fatigue

Head: ☐ Headaches / Migraines ☐ Vertigo / Dizziness

Ears: ☐ Discharge ☐ Ringing in Ears ☐ Infection ☐ Pain

Eyes: ☐ Blurred Vision ☐ Watery Eyes ☐ Itchiness

Nose/Throat: ☐ Sinus Infection ☐ Drainage / Discharge ☐ Sore Throat ☐ Mass

Cardiovascular: ☐ Palpitation ☐ Chest Pain ☐ Calf Pain w/walking ☐ Cold Feet

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough

GI: ☐ Pain ☐ Bleeding/Ulcers ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting

GU: ☐ Incontinence ☐ Urgency ☐ Frequency ☐ Painful Urination ☐ Bleeding

Skin: ☐ Discoloration ☐ Itching/Burning ☐ Bruising ☐ Palpable Mass

Endocrine: ☐ Polyuria (increased urination) ☐ Polyphagia (increased eating)

Musculoskeletal: ☐ Weakness ☐ Joint Pain ☐ Muscle Ache

Neurological: ☐ Numbness ☐ Paralysis ☐ Tremor ☐ Sensory Disturbance

Psychiatric: ☐ Anxiety ☐ Depression ☐ Hallucinations

Family Medical History

Has anyone in your family had any of the following conditions? If so, mark the box and state who, and if possible further describe the condition.

- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis: Type_____
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer: Type_____
- ☐ Depression
- ☐ Diabetes (Circle I **OR** II)
- ☐ DVT (Blood Clot)
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease / Coranary Artery Disease
- ☐ Hepatitis (Circle A/B/C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Psychiatric Disorder
- ☐ Osteoporosis/penia
- ☐ Stroke
- ☐ Thyroid Disorder

Social History

Have you ever smoked?

☐ Yes ☐ No If so, # of years____________ #packs/day__________________

Do you smoke now?

☐ Yes ☐ No If so, # of packs/day__________________

Do you use recreational drugs?

☐ Yes ☐ No If so, Types ___________ #times/week_________________

Do you drink alcohol?

☐ Yes ☐ No If so, # of times/week__________________

Do you drink caffeine?

☐ Yes ☐ No If so, # of times/day___________________

Do you exercise?

☐ Yes ☐ No If so, type___________ # of times/week__________________

What type of shoes do you normally wear?

☐ Flat ☐ Heels ☐ Boots ☐ Loafers ☐ Oxfords

☐ Sandals ☐ Sneakers ☐ Other:________________________________

Please provide any other pertinent information in the box below:

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

______________________________ ______________________________

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

______________________________ ______________________________

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

____

SIGNATURE

____

DATE

NOTICE OF PHOTOGRAPHY TO DOCUMENT CARE:

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Morgan Hill Foot and Ankle Center will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Morgan Hill Foot and Ankle Center's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

____

SIGNATURE

____

DATE