COASTAL PODIATRY
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2 JAMES WAY, SUITE 205
PISMO BEACH, CA 93449

DATE: ___/____/____

PATIENT NAME: _____ _____ ___
FIRST LAST MI

DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F SOCIAL SECURITY # _____

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) _____-_____ YES NO **PRIMARY CARE DOCTOR**: _____

CELL PHONE #: (____) _____-_____ YES NO **WHO REFERRED YOU TO US?** _____

EMAIL ADDRESS: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) _____-_____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) _____-_____

ALLERGIES: ☐ NONE KNOWN ☐ TAPE ☐ LATEX ☐ SULFA ☐ IODINE ☐ OTHER_____

PRESCRIPTION MEDICATIONS

NAME:	DOSE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

USE BACK OF THIS SHEET IF NEEDED.

PAST MEDICAL HISTORY

HAVE YOU **EVER HAD**, OR **BEEN TREATED** FOR, ANY OF THE FOLLOWING?

- ☐ AIDS/HIV
- ☐ ALCOHOLISM
- ☐ ANGINA (CHEST PAIN)
- ☐ AORTIC ANEURYSM
- ☐ APPENDICITIS
- ☐ ARTERIOSCLEROSIS (POOR CIRCULATION)
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ CANCER
- ☐ CARDIAC ARREST (HEART ATTACK)
- ☐ CARDIAC ARRHYTHMIAS
- ☐ CARDIAC DISEASE (CHF)
- ☐ CARDIOMYOPATHY
- ☐ CELIAC DISEASE
- ☐ CLAUDICATION (LEG PAIN WHEN WALKING)
- ☐ CROHN'S DISEASE
- ☐ DIABETES
- ☐ DIZZINESS/FAINTING
- ☐ EDEMA (SWELLING)
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FEMORAL POPLITEAL BYPASS
- ☐ GERD
- ☐ GOITER
- ☐ GOUT
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HYPERLIPIDEMIA (HIGH CHOLESTEROL)
- ☐ HYPERTENSION
- ☐ HYPOTENSION
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY PROBLEMS
- ☐ LEFT VENTRICULAR DYSFUNCTION
- ☐ LUPUS
- ☐ LYMPHEDEMA
- ☐ MULTIPLE SCLEROSIS
- ☐ MURMUR, HEART
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER
- ☐ PHLEBITIS
- ☐ PLEURISY
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PSYCHIATRIC PROBLEMS
- ☐ PVD (PERIPHERAL VASCULAR DISEASE)
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATIC HEART DISEASE
- ☐ SCARLET FEVER
- ☐ SEIZURES
- ☐ STD'S
- ☐ STROKE
- ☐ THROMBOPHLEBITIS
- ☐ THYROID DISORDER
- ☐ ULCERS (GASTRIC)
- ☐ VARICOSE VEINS
- ☐ WEIGHT CHANGE

PLEASE LIST ALL PRIOR **SURGERIES**:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HYPERTENSION
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

SOCIAL HISTORY

USE OF **ALCOHOL**: ☐ NON-DRINKER ☐ MODERATE DRINKER ☐ HEAVY DRINKER ☐ RECOVERING ALCOHOLIC
EMPLOYMENT: ☐ DISABLED ☐ FULL TIME STUDENT ☐ PART-TIME STUDENT ☐ RETIRED ☐ UNEMPLOYED ☐ EMPLOYED
EXERCISE: ☐ MODERATE ☐ NEVER ☐ OFTEN
USE OF **TOBACCO**: ☐ NEVER SMOKED ☐ FORMER SMOKER: WHEN DID YOU STOP SMOKING?_____
☐ LIGHT SMOKER ☐ HEAVY SMOKER

REVIEW OF SYMPTOMS: DO YOU HAVE THESE SYMPTOMS?

Constitutional:
☐ ANXIETY
☐ CHILLS
☐ DIZZINESS
☐ FAINTING
☐ FEVER
☐ LOSS OF APPETITE
☐ MIGRAINE
☐ STROKE
☐ NAUSEA & VOMITING
☐ TIREDNESS
☐ WEIGHT GAIN
☐ WEIGHT LOSS

CV:
☐ CHEST PAIN
☐ COLD FEET
☐ CRAMPING
☐ HEART PALPITATIONS
☐ MURMUR
☐ PACEMAKER
☐ RAPID HEARTBEAT
☐ SHORTNESS OF BREATH
☐ VARICOSE VEINS

ENDOCRINE:
☐ BLOOD SUGAR (HIGH)
☐ BRONZING OF SKIN
☐ DELAY WOUND HEALING
☐ EXCESSIVE THIRST
☐ FATIGUE
☐ HAIR LOSS
☐ INTOLERANCE TO COLD

ENMT:
☐ CONGESTION
☐ COUGH
☐ DIFFICULTY HEARING
☐ DIFFICULTY SMELLING
☐ DIFFICULTY SWALLOWING
☐ EAR PAIN
☐ EAR RINGING
☐ NOSE BLEED
☐ TEETH PAINFUL
☐ THROAT SORE

EYES:
☐ BLURRED VISION
☐ CLOUDY VISION
☐ EYE TRAUMA
☐ LOSS OF VISION
☐ PHOTOSENSITIVITY

GI:
☐ ABDOMINAL PAIN
☐ BLOOD IN STOOL
☐ CONSTIPATION
☐ DIARRHEA
☐ HEARTBURN
☐ INDIGESTION
☐ UPSET STOMACH
☐ VOMITING
☐ GERD

GU:
☐ BLADDER SPASM
☐ BLOOD IN URINE
☐ EXCESSIVE URINATION
☐ KIDNEY (FLANK) PAIN
☐ KIDNEY FAILURE

IMMUNOLOGIC:
☐ ARTHRITIC FLARE-UP
☐ ASTHMA ATTACK
☐ COUGHING
☐ GOUTY ATTACK
☐ HEPATITIS B CARRIER
☐ SEASONAL ALLERGIES

INTEGUMENTARY:
☐ ATHLETE'S FOOT
☐ BURNING OF SKIN
☐ CONTACT DERMATITIS
☐ DERMATITIS
☐ ECZEMA
☐ HYPERSENSITIVE SKIN
☐ ULCERS (SKIN)
☐ PSORIASIS

LYMPHATIC:
☐ ANEMIA
☐ BRUISING EASILY
☐ CALF PAIN
☐ FATIGUE
☐ SWOLLEN ANKLES
☐ SWOLLEN LEGS

MSK:
☐ BACK PAIN
☐ DIFFICULTY WALKING
☐ EPISODIC WEAKNESS
☐ HIP PAIN
☐ DIFFICULT TO WALK
☐ JOINT PAIN
☐ JOINT SWELLING
☐ LEG CRAMPS
☐ MUSCLES TENDER
☐ NECK PAIN
☐ WEAKNESS

NEUROLOGICAL:
☐ BURNING
☐ PARALYSIS
☐ STOCKING NUMBNESS
☐ TINGLING

PSYCHIATRIC:
☐ DEPRESSION
☐ FORGETFULNESS
☐ IRRITABILITY

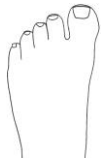
RESPIRATORY:
☐ ASTHMA
☐ COLD-LIKE SYMPTOMS
☐ COUGHING
☐ DIFFICULTY BREATHING
☐ FLU-LIKE SYMPTOMS
☐ SLEEP APNEA

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS/ YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved
What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ Other _____
What makes your pain or problem feel better? _____
_____

What treatments have you had for this problem? _____
_____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ No ☐ YES (describe) _____
_____

Patient Financial Policy

Due to the complicated nature of health insurance, your understanding of our financial polices is essential to your care and treatment. If you have any questions, please do not hesitate to ask out front office staff.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, payment for office services are due at the time of service. We accept cash, check, VISA, and MasterCard.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance pay the doctor directly.
- We have made prior arrangements with most insurers to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be 'not covered,' or you do not have authorization, you will be Responsible for the complete charge. You are responsible for charges to any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered if they have any doubt of coverage.
- You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- A custom brace or custom orthotic are NOT refundable. You may not return a custom brace or custom orthotic for any reason. You understand that you are responsible for charges not covered by your insurance for custom braces or orthotics.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- There is a service charge of **$25.00** for all returned checks. Your insurance company does not cover this fee.
- There is a **$20** fee for appointments missed without 24 hour notification.
- Occasionally you may have a form (DMV, disability, insurance, etc) for the doctor to complete. Depending on the complexity of the form, if you choose to have it completed by the doctor without scheduling an office visit, you may be billed **$15** per form.
- If you need copies of your records for any reason, there will be a **$15** fee for this service. Prices may vary depending on the amount of paperwork to be copied.

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.

_____ _____
Signature Date