PATIENT INFORMATION FORM

THUNDERBIRD
FOOTCARE
Podiatric Medicine & Surgery

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602-547-2111 | 602-547-0473 Fax | www.thunderbirdfootcare.com

DATE: ___ ___ ___

PATIENT NAME: _____ **DATE OF BIRTH:** ___ ___ ___ **SEX:** M F
FIRST MI LAST

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

RACE/ETHNICITY (CHECK ONE) ☐CAUCASIAN/WHITE ☐BLACK/AFRICAN AMERICAN ☐ASIAN ☐NATIVE AMERICAN ☐LATIN/HISPANIC ☐OTHER ☐PREFER NOT TO ANSWER

I GIVE THUNDERBIRD FOOTCARE PERMISSION TO CALL ME AND/OR USE MY EMAIL ADDRESS

HOME PHONE #: _____ ☐YES ☐NO

CELL PHONE#: _____ ☐YES ☐NO

WORK PHONE #: _____ ☐YES ☐NO

****E-MAIL:** _____ ☐YES ☐NO

** YOUR EMAIL ADDRESS IS REQUIRED FOR THUNDERBIRD FOOTCARE - PATIENT PORTAL - SECURED PATIENT MEDICAL INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____ FAX: _____

REFERRING DOCTOR: _____ PHONE: _____ FAX: _____

PHARMACY: _____ LOCATION: _____ PHONE #: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? ☐YES ☐NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE: _____

IF INJURY WAS RELATED TO AUTO/WORK ACCIDENT/ETC., SEE FRONT OFFICE PERSONNEL BEFORE COMPLETING

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ INSURED BIRTHDATE _____
EMPLOYER: _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ INSURED BIRTHDATE _____
EMPLOYER _____ _____

SIGNATURE _____ DATE _____

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PATIENT NAME: _____
LAST FIRST MI

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ **OCCUPATION:** _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____
☐ ELDERLY OR DISABLED FAMILY MEMBER _____ ☐ SPOUSE _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

DO YOU HAVE A FAMILY HISTORY OF:
☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING/ PLEASE GIVE LIST TO FRONT OFFICE
(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS, VITAMINS ETC.)

NAME	DOSE	HOW OFTEN DO YOU TAKE?

ALLERGIES: PLEASE LIST _____

PLEASE LIST ALL PRIOR SURGERIES & DATE

_____
_____
_____
_____

PLEASE LIST ALL HOSPITALIZATIONS & DATE

_____
_____
_____
_____

☐ **CURRENT FLU SHOT DATE** _____ ☐ **PNEUMONIA SHOT DATE** _____

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PATIENT NAME: _____
LAST FIRST MI

YOUR MEDICAL HISTORY

HEIGHT: _____ **WEIGHT** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

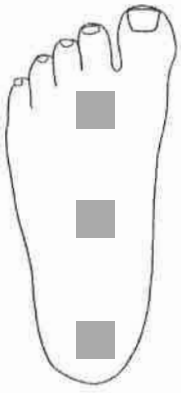
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS - CIRCLE RHEUMATOID OR OSTEOARTHRITIS	Y	N	HIGH CHOLESTEROL	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS A B C	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
YEAR OF DIAGNOSIS CURRENT DIABETIC HGA1C%			DR. FOR DIABETES CARE			FAX#		

CURRENT PROBLEM

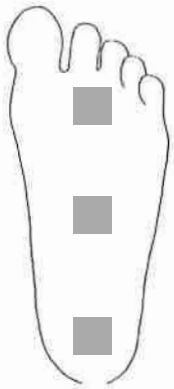
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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

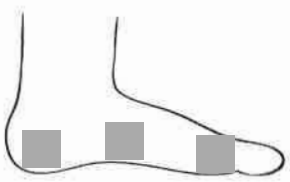
LEFT FOOT



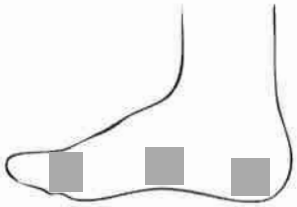
TOP OF FOOT



BOTTOM OF FOOT

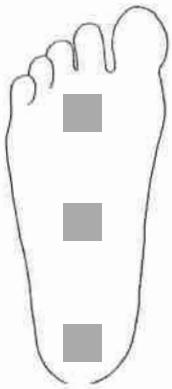


INSIDE OF FOOT

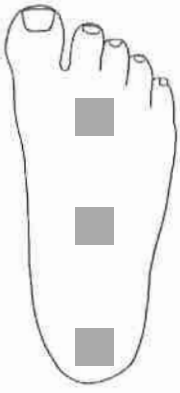


OUTSIDE OF FOOT

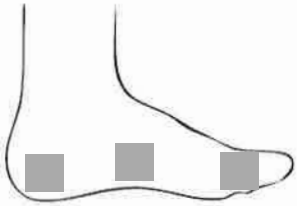
RIGHT FOOT



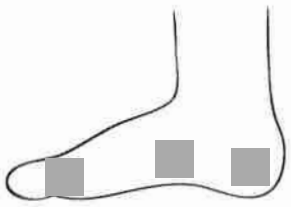
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

THUNDERBIRD
FOOTCARE

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PATIENT NAME: _____
LAST FIRST MI

WHAT IS YOUR SHOE SIZE? _____

WHAT TYPE OF SHOES DO YOU COMMONLY WEAR? CHECK ONE: ☐ SNEAKERS ☐ DRESS ☐ SANDALS ☐ FLIP FLOPS ☐ FLAT SHOES ☐ SLIPPERS ☐ HEELS ☐ WORKS BOOTS ☐ OTHER _____

HAVE YOU SEEN ANOTHER PODIATRIST FOR THIS CURRENT PROBLEM ☐ YES ☐ NO

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

DID YOUR FOOT PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY OVER TIME ☐ OTHER
PLEASE EXPLAIN _____

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 CHECK)
(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 ☐ BECAME 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 PROBLEM 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? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO **IF YES, PLEASE SEE FRONT OFFICE STAFF**

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

_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE _____ DATE _____