Foot and Ankle Associates of North Naples, PA
Greentree Professional Centre
10621 Airport Road North Suite #4
Naples, Florida 34109

Phone 239.592.0700
Fax 239.592.0700
NaplesFootandAnkle.com

Name _____ Date: _____ / _____ / _____

DOB _____ / _____ / _____ Age _____ SS# _____

Local Address _____City_____State_____Zip_____

Home Phone # _____ Work Phone # _____

Cell# _____ e-mail _____

Seasonal Residents (northern address) _____

Primary Insurance _____

Insured name _____ DOB _____ / _____ /_____

Insurance ID # _____ Group # _____

Place of Employment _____ Relationship to Insured _____

I authorize the release of medical information necessary to process this claim. I authorize and request payment of the insurance money to Foot and Ankle Associates of North Naples, PA

Signature _____ Date _____ / _____ / _____

I accept full responsibility for all charges incurred for services rendered. I understand that all fees are payable at the time of service unless specific arrangements have been made prior to the visit. A $25.00 fee will be charged to your account if appointments are not canceled at least 24 hours in advance.

Signature _____ Date _____ / _____ / _____

Primary Care Doctor _____

Height _____ Weight _____ BP _____

List Current Medications _____

_____

Allergies? Y N **(*DESCRIBE*)** _____

Smoking History **(CIRCLE one)** Never Smoked Former Smoker Current Smoker

What problem are you having today?_____

How long has this been going on? _____

How did your problem start? Do you relate it to anything? An injury? _____

How would you describe your pain? Sharp Pain Shooting Pain Dull Ache

On a scale of 1 to 10, with 10 being the worst, rate your pain **(CIRCLE)** 1 2 3 4 5 6 7 8 9 10

Has anything made it better or worse? _____

Have you noticed any other problem(s) because of this? _____

Have you seen another doctor for your foot problems? YES NO How long ago? _____

List recent hospitalizations, surgeries, or serious injuries _____

_____

Past Medical History (CIRCLE any that apply to you)

AIDs/HIV	Diabetes	Liver/Kidney Disease
Anemia	Epilepsy	Osteoporosis
Arthritis	Gout	Phlebitis
Asthma	Heart Disease	Rheumatic Disease
Back problems	Hepatitis	Stroke
Bleeding disorders	High Cholesterol	Tuberculosis
Cancer	Hypertension	

Family History (CIRCLE any that occur in your family)

Diabetes	High cholesterol	Osteoporosis
Heart disease	Hypertension	Cancer

Mother deceased? Y N Father deceased? Y N

Social History (CIRCLE what applies to you)

Tobacco use? Y N Alcohol? Y N Recreational drugs? Y N

Do you exercise? Y N ***(DESCRIBE)***_____

Systems *Review* (CIRCLE any that apply to you)

Ankle pain? Athlete's feet? Bunions? Heel Pain? Ingrown toenail? Plantar wart?
Corns/Calluses? Muscle cramps? Numbness? Flat feet? Foot Swelling?

Changes in weight? Fatigue?

Changes in vision or blurriness? Red Eye?

Lumps on the head/neck? Difficulty hearing? Ear pain or discharge? Tooth pain or problems?

Coughing? Wheezing?

Chest pain or pressure? Shortness of breath? Leg swelling? Heart palpations? Walking pain?

Heart burn? Difficulty swallowing? Nausea or Vomiting? Jaundice? Constipation? Diarrhea?

Blood in urine? Burning with urination? Urgency? Frequency?

Fevers, chills, sweats? Abnormal bleeding/bruising?

Fainting? Seizures? Numbness? Weakness? Dizziness? Balance problems? Headache?

Joint pain and/or Swelling? Muscle ache? Low back pain?

Depression? Anxiety? Memory problems? Confusion?

Hair loss? Skin rashes? Ulcers? Itching?