MICHIGAN FOOT AND ANKLE

Patient History Questionnaire – New Patient

Name ____ Age __________ Date ________________

SS # ____ Birthdate _________ Marital Status ______

Address ____

Telephone: Home ___________________ Work _________________ Email _____________________

Next of Kin/Emergency Contact (name and phone No.) ____

____

How were you referred to our office? Patient ________ Doctor's office ________ Other ________

Referral Doctor (if checked above) ____

Other (if checked above ____

Employer ____

Employer Address ____

Employer Phone Number ____

INSURANCE INFORMATION

Type of Insurance ______________________________ Policyholder ______________________________

Policyholder Birthdate ____

Policyholder Address ____

Relationship to Patient ____

Policyholder Employer ____

Employer Address ____

____

Employer Contact & Phone Number ____

Name ____ Date ______________________________

CHIEF COMPLAINT What brought you to the doctor today?

____

Is this condition work related? ☐ Yes ☐ No Did this injury occur at school? ☐ Yes ☐ No

Is this condition auto related ☐ Yes ☐ No Other injury? ☐ Yes ☐ No

Past Medical History Do you have a history of any of the following?

☐ Hypertension	☐ Diabetes	☐ Stroke	☐ Nervousness	☐ Tumors
☐ Heart/Circulation Trouble	☐ Hypoglycemia	☐ Emphysema	☐ Epilepsy	☐ Cancer
☐ Glaucoma	☐ Kidney Disease	☐ Ulcers	☐ Epilepsy	☐ HIV/AIDS
☐ Asthma	☐ Liver Disease	☐ Rheumatism/Arthritis	☐ Anemia	☐ Hepatitis
☐ Bleeding Tendencies	☐ Thyroid Disease	☐ Varicose Veins	☐ Drug Abuse	
☐ Tuberculosis	☐ Gout	☐ Leg Cramps	☐ Mitral Valve Prolapse	

Past Surgical History Have you had any surgery before _______ Yes _______ No

If yes, please list procedure and date ____

General Health ☐ Good ☐ Fair ☐ Poor Height ___________ Weight ____________

Type of Problem

☐ Corns, Callous, Nails	☐ Fracture/Sprains	☐ Warts, Tumors	☐ Bunions, Hammertoes
☐ Diabetic Foot Care	☐ Ingrown Nail	☐ Ankle Pain	☐ Neuroma or Nerve Pain
☐ Other			

Date It Began _____________ Home Treatment/Response ____

Allergies Do you have any allergies to medications? _______ Yes _______ No

☐ Penicillin	☐ Sulfa	☐ Codeine	☐ Demurral	☐ Aspirin
☐ Novocain	☐ Tetracycline	☐ Darvon	☐ Anesthetics	☐ Seconal
☐ Tetnus	☐ Anesthetics	☐ Antihistamines	☐ Mercurial	☐ Iodine
☐ Merthiolate	☐ Adhesives	☐ Iodine	☐ Nylon/Plastic	

☐ Other ________________________________

Are you allergic to latex products? ______ Yes _______ No

Medications List all prescription medications you take; include dosage and frequency. Insulin, inhaler And patches should be included here

____

____

List all non-prescription medications you take routinely _____________________________________

____

Name ______________________________ Date ____________________

Social History

Do you smoke _______ Yes _______ No How Much _______________

Do you drink alcohol _______ Yes _______ No How Much _______________

What type of job do you have ____

Family History Do any illnesses run in your family

____

____

Review of Systems Please check if you have any of the following

CONSTITUTIONAL
- ______ Fever
- ______ Weight loss
- ______ Lethargy

EARS, NOSE, MOUTH & THROAT
- ______ Tinnitis
- ______ Nose bleeds
- ______ Nasal congestion
- ______ Sore throat
- ______ Difficulty swallowing

GENITOURINARY
- ______ Frequency
- ______ Blood in urine
- ______ Abnormal urine color
- ______ Painful urination
- ______ Awaken to urinate
- ______ Unable to fully empty bladder
- ______ Incontinence

HEMATOLOGIC/ LYMPHATIC
- ______ Easy bruising
- ______ Anemia
- ______ Blood abnormalities
- ______ Blood thinners
- ______ Lymph node enlargement

EYES
- _____ Blurred vision
- _____ Cataracts
- _____ Glasses

RESPIRATORY
- _____ Chronic cough
- _____ Wheezing
- _____ Emphysema
- _____ Cough blood
- _____ Productive cough
- _____ Asthma

MUSCULOSKELETAL
- _____ Pain
- _____ Limited range of motion
- _____ Limited strength
- _____ Arthritis

NEUROLOGICAL
- _____ Headache
- _____ Fainting
- _____ Dizziness
- _____ Memory loss
- _____ Numbness

CARDIOVASCULAR
- _____ Shortness of breath
- _____ Chest pain (angina)
- _____ Heart palpitations
- _____ Heart attack
- _____ Stroke
- _____ Cold extremities
- _____ Hypertension

GASTROINTESTINAL
- _____ Pain
- _____ Diarrhea
- _____ Constipation
- _____ Blood in stool
- _____ Mucus in stool
- _____ Nausea
- _____ Vomiting
- _____ Vomit blood
- _____ Heartburn
- _____ Change in stool
- _____ Food intolerance
- _____ Loss of appetite

INTEGUMENTRY
- _____ Rash
- _____ Itching
- _____ Dry Skin

ENDOCRINE
- _____ Night sweats
- _____ Thyroid disease
- _____ Diabetes

Reviewed ______________________________

Name ____ Date ___________________________

ACCEPTANCE OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

FINANCIAL RESPONSIBILITY: Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We therefore urge you, the patient, to please check with your insurance company prior to any office visit/procedure. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, or guardian being responsible for all costs incurred. Delinquent accounts may be subject to collection, service fee and/or interest. Non-coverage delinquent fees may be charged a monthly interest of 1.5% per month. Please remember your insurance policy is between you and your company, not the insurance company and your doctor.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialists, PC and Associates, for any services furnished to me by that physician or his associates. I authorize any holder of medical information to release it to the Health Care Financing Administration/Other Insurance Company and its agents any information needed to determine these benefits payable to related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance Company assigned cases, the physician agrees to accept the charge determined as full charge, and the patient is responsible for only the deductible, coinsurance, copays and non-covered services. Coinsurance, deductibles and copays are based upon the charge determination of Medicare/Other Insurance Company.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any holder of information concerning my treatment to release that information to the Social Security Administration and its intermediaries, insurance carriers or other governmental offices if needed for this or related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information relating to treatment for serious communicable diseases, (as defined by the Michigan Public Health Code), to my Health Plan Administrator, its agents and representatives, insurance carrier or its authorized agent, for the purpose of conduction, concurrent or retrospective, of medical review of treatment and services provided at Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialists, PC and Associates. I understand that duplicate copy of this authorization may be used and is as acceptable as the original and may not be revoked unless a request is submitted by me in writing. I hereby give my permission to Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialists, PC and Associates, to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature ____
Patient

Signature ____ ______________________
Guardian Relationship