Robert A. Iannacone, DPM, P.A. Chart#_____

Patient Name:_____ **Date:**_____

Name: _____ DOB:_____ Age: _____ Sex: ☐ Male ☐ Female

Address:_____ City:_____ State_____ Zip:_____

Home Number:_____ Cell/Work Number: _____ SS#_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouse/Partner Name : _____

Race:_____ Ethnicity_____ Preferred Language: _____

Primary Care Physician: _____ Phone:_____ Date Last Seen:_____

Pharmacy and Location: _____ Phone:_____

How did you found out about our practice? ☐ Physician ☐ Internet ☐ Telephone Book ☐ Family ☐ Friend

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Insurance Information:

Primary Insurance:_____ Secondary Insurance:_____

Policy ID number: _____ Policy ID number: _____

Privacy Information Preferences:

Do you want to be exempt from public reporting?	☐ Yes	☐ No
Can our office send mail to the address on file?	☐ Yes	☐ No
Can our office call the phone number(s) on file?	☐ Yes	☐ No
Can our office leave a voicemail message on the answering machine?	☐ Yes	☐ No
Would you like internet based reminders, such as email?	☐ Yes	☐ No

If yes, what is your email?_____

Who can we leave any messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:_____

Have you completed any Advanced Directives? ☐Yes ☐No

AUTHORIZATION FOR TREATMENT:

I voluntarily consent to the rendering of medical care by **Robert A. Iannacone, DPM.** I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s). I guarantee payment of any and all bills rendered for said patient which are not covered or allowed by insurance. This office will file the bill with my insurance company, providing I supply the proper insurance information. I authorize **Robert A. Iannacone, DPM** to retrieve my medication history. I authorize **Robert A. Iannacone, DPM** to release any and all information required in the course of my examination and/or treatment for the purpose of insurance, worker's compensation or Medicare benefit payments. I acknowledge that procedures and services not covered by my insurance company will be my responsibility and payment will be expected when services are rendered. I acknowledge that I am aware and have been given the opportunity to obtain and read a copy of the Notice of Privacy Practices and understand this Notice. **Medicare Patients:** I certify that the information given to me to submit for payment under Title XVII of the Social Security Act is correct. I authorize the release of the medical and other information held by this office to the Social Security Administration or its carriers required for the submission of medical claims and reimbursement for services rendered.

Sign:_____ **Date:**_____

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. Sign_____ **date**_____

Robert A. Iannacone, DPM, P.A.

Chart#_____

Patient Name:_____ **Date:**_____

What is the reason for your visit today? _____

How long has this bothered you? 1 2 3 4 5 6 7 8 9 10 11 12 ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Other:_____

When is the pain the worst?_____

What treatments have you tried?_____ Where they effective? ☐ Yes ☐ No

On a scale of 1 – 10 (*10 being the worst*) what is your level of pain? _____ / 10

Pain quality: ☐ Burning ☐ Constant ☐ Dull ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Other: _____

*Are you Pregnant? ☐ Yes ☐ No *Are you nursing? ☐ Yes ☐ No

Medical History: ☐ None

- ☐ Alcoholism
- ☐ Asthma
- ☐ Arthritis: Osteo or Rheumatoid
- ☐ Anxiety Disorder
- ☐ AIDS/HIV
- ☐ Environmental Allergies
- ☐ Blood Disorders: _____
- ☐ Breathing Issues:_____
- ☐ Blood Clot:_____
- ☐ Circulation Problems:_____

*Flu Shot ☐ Yes ☐ No Date_____

- ☐ Depression
- ☐ Diabetes: Type _____
- ☐ Gout
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Musculoskeletal:_____

*Pneumococcal Vaccine ☐ Yes ☐ No

- ☐ Neuropathy:_____
- ☐ Neurological:_____
- ☐ Osteoporosis
- ☐ Skin Disorder:_____
- ☐ Stomach/Bowel: _____
- ☐ Sleep Apnea
- ☐ Thyroid Disease:_____
- ☐ Other: _____

Have you fallen in the last 12 months? _____

Current Medications: (*list can also be given*) ☐ None

Name:_____ Dose:_____ Name:_____ Dose: _____

Name:_____ Dose: _____ Name:_____ Dose: _____

Name:_____ Dose:_____ Name:_____ Dose: _____

Current Allergies and Reactions: ☐ No Known Drug Allergies

- ☐ Penicillin_____
- ☐ Tylenol_____
- ☐ Sulfa_____
- ☐ Latex_____
- ☐ Aspirin_____
- ☐ Ibuprofen_____
- ☐ Codeine_____
- ☐ ACE Inhibitors_____
- ☐ Betadine (Iodine) _____
- ☐ Shellfish_____
- ☐ Tape_____
- ☐ Other_____

Surgical History: ☐ None

- ☐ Appendectomy: yr _____
- ☐ Adenoidectomy: yr_____
- ☐ Artificial joints - Where?_____
- ☐ Angioplasty: yr _____
- ☐ Back: yr_____
- ☐ Biopsy: yr_____
- ☐ Bypass: yr _____
- ☐ Cataracts: yr _____
- ☐ C-Section: yr _____
- ☐ D&C: yr _____
- ☐ Gallbladder: yr _____
- ☐ Hemorrhoidectomy: yr _____
- ☐ Hernia: yr_____
- ☐ Hysterectomy: yr _____
- ☐ Knee: yr _____ Lt or Rt
- ☐ Mastectomy: yr_____
- ☐ Neck: yr_____
- ☐ Shoulder: yr _____ Lt or Rt
- ☐ Tonsillectomy: yr _____

Do you have an artificial heart valve? ☐ Yes ☐ No

If a surgery that you have had is not listed above, please list it here:_____

_____

Have you ever had any surgical procedures on your foot/ankle? ☐ Yes ☐ No Please explain:_____

_____

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Patient Name:_____ **Date:**_____

Social History:

Age:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouse/Partner Name : _____

Do you live alone? ☐ Yes ☐ No If no, with who?_____

What is your occupation?_____ It involves mostly: ☐ Sitting ☐ Standing or ☐ I am retired

Do you Exercise regularly? ☐ Yes ☐ No If yes, please explain:_____ How often?_____

Do you have any Hobbies? ☐ Yes ☐ No If yes, please explain:_____

Smoking status? ☐Former ☐Never ☐ Current every day smoker - How long?_____ ☐Current some day smoker ☐ Other

Do you drink alcohol? ☐ Yes ☐ No If yes, how often?_____

Substance abuse: ☐ Yes ☐ No please specify_____

Family History: (*please list any family blood relatives who have had any of these issues*)

☐ Adopted		☐ Circulation issues	_____	☐ Heart disease	_____
☐ Alzheimer's	_____	☐ Depression	_____	☐ High Blood Pressure	_____
☐ Arthritis	_____	☐ Diabetes	_____	☐ High Cholesterol	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____	☐ Neurological	_____
☐ Blood Clot	_____	☐ Gout	_____	☐ Stroke	_____
☐ Cancer	_____	☐ Heart attack	_____		
☐ Cataracts	_____				

Review of systems: *(please check the box if you have had any of these symptoms)*

Cardiovascular:
- ☐ Leg pain when walking
- ☐ Fever
- ☐ Chest pain/pressure
- ☐ Leg swelling
- ☐ Cold hands/feet
- ☐ Fainting
- ☐ Palpitations
- ☐ Vascular disease
- ☐ Valve problems

Genitourinary:
- ☐ Blood in urine
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Increased urgency
- ☐ Decreased frequency
- ☐ Excessive urination
- ☐ Kidney disease
- ☐ Kidney stones

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Vomiting
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Issues swallowing
- ☐ Constipation
- ☐ Increased appetite
- ☐ Decreased appetite

Musculoskeletal:
- ☐ Back pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Sciatica
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint instability
- ☐ Arthritis

Hematologic:
- ☐ Sickle cell disease
- ☐ Anemia
- ☐ Blood thinners
- ☐ Clotting disorders

Neurological:
- ☐ Tingling
- ☐ Weakness
- ☐ Seizures
- ☐ Numbness
- ☐ Headaches
- ☐ Tremors
- ☐ Paralysis

Integumentary:
- ☐ Athletes foot
- ☐ Nail abnormalities
- ☐ Keloids
- ☐ Itchiness
- ☐ Dry, scaly skin
- ☐ Lower leg ulcers

Respiratory:
- ☐ Chest pain
- ☐ Wheezing
- ☐ COPD
- ☐ Coughing
- ☐ Snoring
- ☐ Shortness of breath
- ☐ Emphysema

If there is anything else you would like us to know about, please explain below:

_____

_____

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