ST. LOUIS FOOT AND ANKLE INSTITUTE

Please complete the following health questionnaire. We are concerned with your overall health as well as your foot and ankle problems. This information is confidential and will be reviewed by your doctor today. It is designed to help your recall your medical history and provide details that can help with your diagnosis and treatment plan.

Name: _____ **DOB:** _____

Sex: Male Female Other _____ **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ **Mobile #:** _____ **Work #:** _____

Email: _____

May we contact you by phone, email, and/or text? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

Employer: _____ **Phone**: _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone #: _____

May we contact the above regarding your medical information? ☐ Yes ☐ No

Pharmacy Information

Name: _____ **Phone:** _____

Address: _____

ACKNOWLEDGEMENT OF FINANCIAL AND PAYMENT POLICY

I acknowledge that I was provided with a copy of the Financial Policies and that I have read (or had the opportunity to read if I so chose) and understood the Notice. I hereby authorize payment directly to St. Louis Foot and Ankle Institute, LLC of all insurance benefits otherwise payable to me for services rendered. I authorize the above doctor and/or provider or supplier of services and durable medical equipment in this office to release the information required to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature of Responsible Party: _____ Date: _____

ST. LOUIS FOOT AND ANKLE INSTITUTE

HIPAA Privacy and Release of Information Authorization

I, _____, hereby authorize St. Louis Foot and Ankle Institute, LLC and its affiliates, its employees, and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient or Authorized Representative Signature Date

ST. LOUIS FOOT AND ANKLE INSTITUTE

Authorization to Release Information to Other Parties

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of tests, procedures, and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize St. Louis Foot and Ankle Institute, LLC to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to speak with the above individuals or leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____
Patient Signature

_____ _____
Patient Name Date

ST. LOUIS FOOT AND ANKLE INSTITUTE

Patient Name: _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: _____

Who is your Primary Care Doctor? _____

MEDICAL HISTORY

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back pain
- ☐ Bleeding Disorder
- ☐ Blood clots
- ☐ Cancer
  - ○ _____
- ☐ Circulation Problems
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes
  - ○ Type 1
  - ○ Type 2
- ☐ Edema
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
  - ○ A B C
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Leg or Foot Ulcer
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Illness
  - ○ _____
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Psoriatic Arthritis
- ☐ Pulmonary Embolism
- ☐ Raynaud's Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Varicose Veins

SURGICAL HISTORY

- ☐ None
- ☐ Angioplasty
- ☐ Back Surgery
- ☐ Bunion
- ☐ C-section
- ☐ Colonoscopy
- ☐ Cataracts
- ☐ Hammertoe
- ☐ Heart Surgery
- ☐ Joint replacement
  - ○ _____
- ☐ Tonsils/adenoids
- ☐ Wisdom teeth
- ☐ Other (specify)
  - ○ _____
    _____

Have you ever had any surgical procedure on your foot/ankle? ☐ NO

If yes, please describe: _____

ST. LOUIS FOOT AND ANKLE INSTITUTE

FAMILY HISTORY

- ☐ Arthritis
  - ○ _____
- ☐ Blood Clots
  - ○ _____
- ☐ Cancer
  - ○ _____
- ☐ Diabetes
  - ○ _____
- ☐ Gout
  - ○ _____
- ☐ High Blood Pressure
  - ○ _____
- ☐ High Cholesterol
  - ○ _____
- ☐ Heart Disease
  - ○ _____
- ☐ Kidney Disease
  - ○ _____
- ☐ Liver Disease
  - ○ _____
- ☐ Osteoarthritis
  - ○ _____
- ☐ Osteoporosis
  - ○ _____
- ☐ Rheumatoid Arthritis
  - ○ _____
- ☐ Other (specify)
  - ○ _____
    _____

SOCIAL HISTORY

Do you have an Advanced Directive? ☐ Yes ☐ No
Do you have a medical Power of Attorney? ☐ Yes ☐ No

What is your occupation? _____

Smoking

- ☐ No
- ☐ Yes
  - ○ Packs per day □ ½ □ 1 □ 2 □ 3 □ 4
  - ○ Age started smoking _____
- ☐ Former
  - ○ Quit Date _____
  - ○ Age started smoking _____

Alcohol Consumption

- ☐ No
- ☐ Yes ☐ Daily (5-7 days/week) ☐ Weekly (1-3x week) ☐ Monthly (2-3x month)

Non-medical drug use

- ☐ No - I do not use medications/chemical substances that have not been prescribed to me.
- ☐ Yes
  - ○ I currently use medications/chemical substances that have not been prescribed to me.
    - ▪ Specify: _____
  - ○ In the past I used medications or chemical substances that had not been prescribed to me.
    - ▪ Specify: _____

- ☐ Do you exercise?
  - ○ No, I do not.
  - ○ Yes, I do the following regular exercise: _____

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Review of Systems (Please check the box if you currently have any of these symptoms)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Exercise intolerance
- ☐ Malaise

Eyes
- ☐ Dry eye
- ☐ Vision change
- ☐ Eye irritation
- ☐ Eye disease
- ☐ Wear glasses or contact lenses

Ears
- ☐ Difficulty hearing
- ☐ Ear pain
- ☐ Ringing

Nose
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Runny nose

Mouth/Throat
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Mouth ulcers
- ☐ Snoring
- ☐ Teeth abnormalities

Cardiovascular
- ☐ Chest pain
- ☐ Arm pain with exertion
- ☐ Shortness of breath with walking
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Leg swelling

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Sleep apnea

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in appetite
- ☐ GERD

Urinary
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Increased frequency
- ☐ Blood in urine

Musculoskeletal
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Cramps

Integument
- ☐ Abnormal mole
- ☐ Rash
- ☐ Itching
- ☐ Dry skin
- ☐ Slow healing wound

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Memory Issues

Endocrine
- ☐ Hair loss
- ☐ Fatigue
- ☐ Cold intolerance
- ☐ Increased thirst

Hematologic/Lymphatic
- ☐ Easy bruising
- ☐ Swollen glands
- ☐ Excessive bleeding
- ☐ Mood swings

How did you hear about St. Louis Foot and Ankle Institute?
- ☐ Physician: _____
- ☐ Family member
- ☐ Internet
- ☐ Family/Friend
- ☐ Insurance website/book
- ☐ Other: _____

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Reason for Visit

☐ New Problem ☐ Continued Problem ☐ Second Opinion ☐ Referral for Surgery

When did this start? _____

What have you tried at home?

- ☐ NSAIDS
- ☐ Rest
- ☐ Ice
- ☐ Elevation
- ☐ Decreasing Activity
- ☐ Home Exercises
- ☐ Stretches
- ☐ Changes in Shoes
- ☐ Shoe Inserts/Orthotics

Have they been effective? ☐ Yes ☐ No

On a scale of 0 – 10 (0 being no pain and 10 being the worst pain you've ever had) what is your current level of pain? _____

The pain is:

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Tingling

What makes the pain worse?

- ☐ Running
- ☐ Walking
- ☐ Standing
- ☐ Certain shoes _____
- ☐ Touching/Rubbing
- ☐ Other_____

Is this condition the result of an injury at work? ☐ Yes ☐ No

- Have notified your employer and the worker's compensation liaison at your employer? ☐ Yes ☐ No
- What is their contact information? _____

Is this condition a result of a motor vehicle accident? ☐ Yes ☐ No

- Are you represented by an attorney? ☐ Yes ☐ No
- What is their contact information? _____

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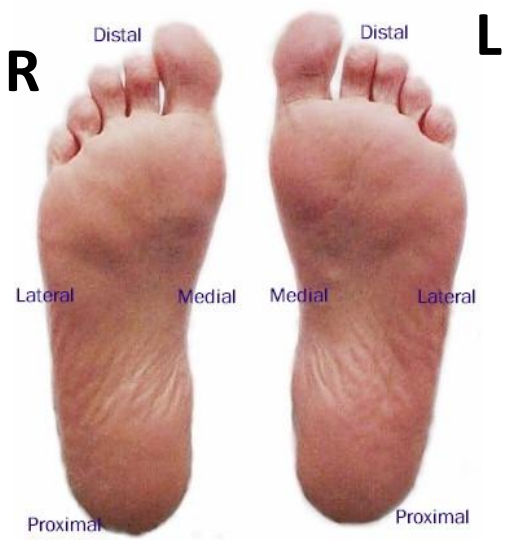
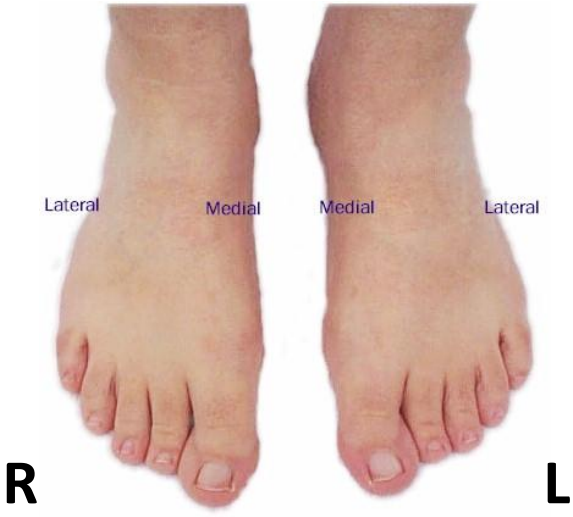
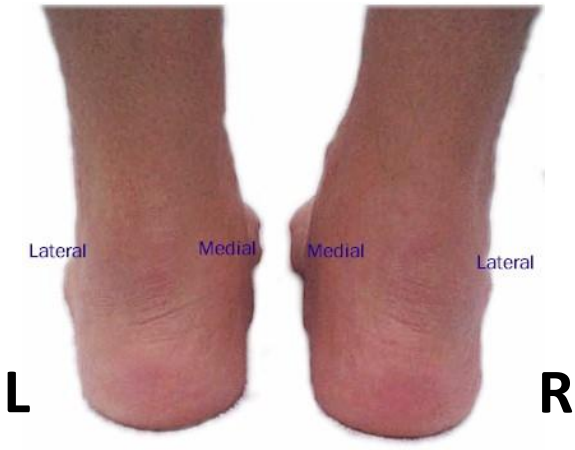
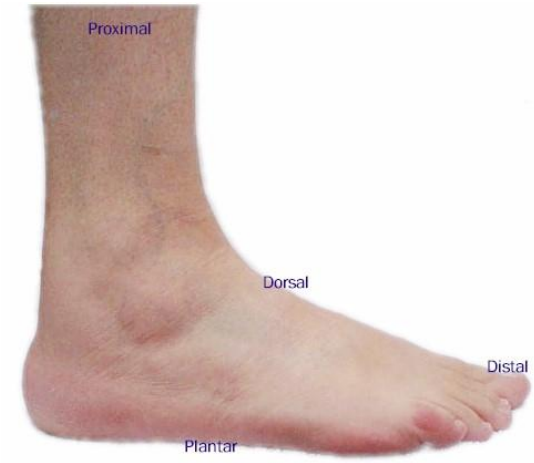
INSTITUTE

Please mark where you are having pain.









****** Please note that the physician and staff of St. Louis Foot and Ankle Institute do not consent to audio or video recordings of any kind during evaluation and treatment. We kindly ask that you silence your phone and refrain from usage during your exam and any treatments. ******

By signing below, I certify that I have read and understood all materials and that 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.

_____ _____

Patient or Authorized Representative Signature Date