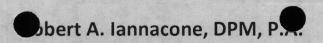


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date\_

		The state of the s	ate:	
Name: D	OB:	Age:	Sex:	☐ Male ☐ Female
Address: City:				
Home Number: Cell/Work Number:		SS#_		
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouse/				
Race: Ethnicity	Pi	referred Language:		
Primary Care Physician: Phone:			Date Last Se	en:
Pharmacy and Location: P	hone:			
How did you found out about our practice? ☐ Physician ☐ Internet	☐ Telephon	e Book 🛚 Family	☐ Friend	
Insurance Information:				
Primary Insurance: Sec	ondary Insu	rance:		
	icy ID numb	er:		
Privacy Information Preferences:				
Do you want to be exempt from public reporting?	☐ Yes	□ No □ No		
Can our office send mail to the address on file?	□ Yes	□ No		
Can our office call the phone number(s) on file?  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, D	PM. Lunders	tand that I am under t	he care and su	pervision of my
attending physician and it is the responsibility of the staff to carry out the instructi				
rendered for said patient which are not covered or allowed by insurance. This office				
proper insurance information. I authorize <b>Robert A. Iannacone</b> , <b>DPM</b> to retrieve				
release any and all information required in the course of my examination and/or tr				
Medicare benefit payments. I acknowledge that procedures and services not cover				
be expected when services are rendered. I acknowledge that I am aware and have	been given th	e opportunity to obtain	n and read a c	opy of the Notice of
Privacy Practices and understand this Notice. Medicare Patients: I certify that th				
Social Security Act is correct. I authorize the release of the medical and other info			ocial Security	Administration or its
	vices rendered			
carriers required for the submission of medical claims and reimbursement for serv				
carriers required for the submission of medical claims and reimbursement for services.  Sign:				

medical staff of any and all updates to the information listed above. Sign\_

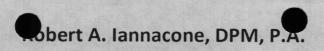


Chart#	
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date

Patient Name:			Date:		
What is the reason for your visit					
			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					
Pain quality: Burning C	Constant 🗆 Dull 🗆 Sha	arp 🗆 Shooting 🗆 Th	robbing 🗆 Tingling 🗆 Other:		
*Are you Pregnant?  Yes  Yes	No *Are you nursing?	Yes No			
Medical History:	e *Flu Shot [	Yes No Date	*Pneumococcal Vaccine ☐ Yes ☐ No		
☐ Alcoholism	☐ Depressi	on	☐ Neuropathy:		
☐ Asthma		: Type			
☐ Arthritis: Osteo or Rheuman			☐ Osteoporosis		
☐ Anxiety Disorder	☐ High Ch	olesterol	☐ Skin Disorder:		
□ AIDS/HIV	☐ Heart Di		☐ Stomach/Bowel:		
☐ Environmental Allergies	☐ High Blo	od Pressure	☐ Sleep Apnea		
☐ Blood Disorders:	Heart M	urmur	☐ Thyroid Disease:		
☐ Breathing Issues:	Breathing Issues:		☐ Other:	Other:	
☐ Blood Clot:		llness	Have you fallen in the last 12 months?		
☐ Circulation Problems:		skeletal:			
Current Medications: (list		□ None			
Name:		Name:			
Name:		Name:	Dose:		
Name:	Dose:	Name:	Dose:		
Current Allergies and Reac	tions: 🗆 No Known	Drug Allergies			
☐ Penicillin	☐ Tylenol	☐ Sulfa	_		
☐ Aspirin	☐ Ibuprofen	☐ Codeine	☐ACE Inhibitors		
☐ Betadine (Iodine)			Other		
Surgical History:   None					
☐ Appendectomy: yr	☐ Biopsy: yr	☐ Gallbladder:	yr Mastectomy: yr		
☐ Adenoidectomy: yr	☐ Bypass: yr	☐ Hemorrhoide	ctomy: yr Neck: yr		
☐ Artificial joints - Where?	_ Cataracts: yr	Hernia: yr	Shoulder: yr Lt or Rt		
☐ Angioplasty: yr	☐ C-Section: yr		: yr		
☐ Back: yr	□ D&C: yr	☐ Knee: yr	Lt or Rt		
Do you have an artificial heart v	alwa?   Vac   INa				
		4 !4 h aug.			
If a surgery that you have had is	not listed above, please ils	t it nere:	April 1990		
Have you ever had any surgical	procedures on your foot/ar	nkle? 🗆 Yes 🗆 No Plea	ase explain:		
The above information is correct to	the best of my knowledge. I	understand that throughou	it my treatment, I am responsible for notifying the physici	ian and	

medical staff of any and all updates to the information listed above. Sign\_



Chart#		
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date

Patient Name:		Date:		
Social History:			Age:	
Do you live alone?  Yes	No If no, with who?			
			Sitting Standing or I am retired	
Do you Exercise regularly?	Yes	in:	How often?	
Do you have any Hobbies? $\square$	Yes	in:	ALL PROPERTY OF THE PARTY OF THE PERTY OF TH	
			Current some day smoker  Othe	
Do you drink alcohol?	es 🗆 No If yes, how often?			
	No please specify			
Family History: (nlease l	ist any family blood relatives	who have had any of these is	squar)	
☐ Adopted	☐ Circulation		☐ Heart disease	
☐ Alzheimer's			☐ High Blood Pressure	
☐ Arthritis	□ Diabetes		☐ High Cholesterol	
	□ Emphysem	19	☐ Neurological	
□ Blood Clot	Gout		☐ Stroke	
☐ Cancer	☐ Heart attac			
☐ Cataracts				
Davious of systems (along	l l- 4l - l 25 1 1			
Cardiovascular:	e check the box if you have he Genitourinary:		Musaulaskalatak	
Leg pain when walking	Blood in urine	Gastrointestinal:  Abdominal pain	Musculoskeletal:	
☐ Fever	☐ Hesitancy	☐ Heartburn	☐ Back pain ☐ Joint swelling	
☐ Chest pain/pressure	☐ Incontinence	☐ Blood in stool	☐ Muscle weakness	
☐ Leg swelling	☐ Increased urgency	□ Vomiting	☐ Muscle pain	
☐ Cold hands/feet	☐ Decreased frequency	☐ Ulcers	☐ Neck pain	
☐ Fainting	☐ Excessive urination	□ Diarrhea	☐ Sciatica	
☐ Palpitations	☐ Kidney disease	☐ Issues swallowing	☐ Joint stiffness	
☐ Vascular disease	☐ Kidney disease	☐ Constipation	☐ Joint stiffless	
☐ Valve problems	La Ridney stolles	☐ Increased appetite	☐ Joint instability	
The valve problems		☐ Decreased appetite	☐ Arthritis	
Hematologic:	Neurological:	Integumentary:	Respiratory:	
☐ Sickle cell disease	☐ Tingling	Athletes foot	☐ Chest pain	
☐ Anemia	☐ Weakness	☐ Nail abnormalities	☐ Wheezing	
☐ Blood thinners	☐ Seizures	☐ Keloids	□ COPD	
☐ Clotting disorders	□ Numbness	☐ Itchiness		
a clotting disorders	☐ Headaches	☐ Dry, scaly skin	☐ Snoring	
	☐ Tremors	☐ Lower leg ulcers	☐ Shortness of breath	
	☐ Paralysis		☐ Emphysema	
	1 at alysis		_ Dispuysema	
If there is anything else yo	ou would like us to know abo	ut, please explain below:		

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