Past Medical History: *circle those pertaining to you*

NONE	Anemia	Anxiety
Arthritis	Asthma	Cancer
Dementia	Depression	Diabetes 1 OR 2
Drug Abuse	Fibromyalgia	GERD
Gout	Heart Disease	Hepatitis
↑cholesterol	↑blood pressure	HIV
IBS	Kidney disease	Liver disease
MRSA	Osteoporosis	Spinal injury
Spinal stenosis	Stroke	Thyroid disease

OTHER:_____

Medications: please list or provide a printed/written list for us to record in your chart. ☐ **check here if you take no medications**

Medication Dosage

_____

_____

_____

_____

_____

We have the ability to communicate with your pharmacy to obtain and update your prescription information electronically. Do we have your permission to do so? ☐ YES ☐ NO

What is your preferred pharmacy? Name and phone number.

_____

Allergies: *If you have allergies, please grade the allergy as mild, moderate, or severe, and list your reaction:*

Allergen Mild/mod/severe Reaction

_____

_____

_____

_____

Social History: *Do you. . .*

-Smoke? N Y, for _____years, ____packs/day
Date quit:_____

-Use alcohol? N Y If yes, is it…..

Occasional (1-4 drinks/wk) Moderate (5-13 drinks/wk) Heavy (>14 drinks/wk)

-Use illegal drugs? N Y

If yes, what type?_____

-Exercise? N Y If yes, how many times/week?_____

What activities do you participate in?_____

_____

Surgical History: Please list any prior surgeries, including those to your foot or ankle:

_____

_____

_____

_____

_____

What is your chief complaint for your podiatrist today? SPECIFY

_____

_____

_____

_____

_____

What is your shoe size?_____

Have you ever been previously treated for this? Yes No

If yes, by whom? _____
Is this an injury that occurred at work? Yes No

Will this be a work comp claim? Yes No

If so, date of injury: _____

Did you miss work due to this injury/condition? Yes No

HIPAA Release: I certify that, in addition to providing the above information, I have been given the opportunity to review the HIPPA privacy acts, and understand that my Private Health Information will not be sold or shared without my permission.

Signature:_____ Date:_____

Consent to treatment, coordination of care, and billing of insurance: I agree, by signing below, that the information given is correct to the best of my knowledge and I consent to such diagnostic procedures (including x rays) and medical care/treatment as deemed necessary by Dr. Cindric. I also authorize Dr. Cindric to discuss my medical issues with other physicians of mine in the best interest in my overall patient care, if necessary. I also authorize release of information to SMB Medical Billing as necessary to file a claim with my insurance company, and assign all benefits payable to Dr. Cindric. I understand I am financially responsible for any balance not covered by my insurance carrier, including any deductible and copayments, as delineated in the practices' financial policy that has been provided to me.

Signature:_____ Date:_____

Thank you for taking the time to fill out this form completely. While much of the information may seem unnecessary or redundant, it will help us to serve you better today and in the future. If you have any questions or need assistance in filling it out, please ask at the front desk. Please return this to the front desk staff when complete, with your insurance card and photo ID. *Thank you!*