Central Arkansas Foot Care

DIVISION OF JOSEPH M. LACAVA DPM, PA

Hot Springs: 501-321-4844 Arkadelphia: 870-245-3003 Fax: 501-321-0956

PATIENT INFORMATION FORM

(Please Print Clearly)

Date: _____

Patient Name: _____Date Of Birth: _____ Age: __Sex: M F

Address: _____City/State: _____ Zip: _____

Home Phone: (____) _____- _____ Cell Phone: (___) ____-_____

Email Address: _____ (WILL NEVER BE SHARED)
What Is The Best Way To Contact You? Home Cell Work Email

Employer: _____Work Phone: (___) ____-_____

Emergency Contact: _____ Relationship: _____ Phone: (___) _____- _____

Primary Care Doctor: _____ Date Last Seen: _____

Phone: (____) _____- _____ Address: _____ City/State: _____

Pharmacy: _____ Location: _____ Phone: (____) _____- _____

Who Is Responsible For Payment? _____ Relationship: _____

Address: _____City/State: _____Phone :(____) _____-_____

Who Referred You To Us?
_____

Insurance Information **( ) see copy**

Primary Insurance Company Name: _____ Phone: (____) _____- _____

Address: _____City/State: _____ Zip: _____

Insured Name: _____ Date of Birth: _____Employer: _____

ID# _____Group#_____

Secondary Insurance Company Name: _____ Phone: (____) ____- _____

Address: _____City/State: _____ Zip: _____

Insured Name: _____ Date of Birth: _____Employer: _____

ID# _____Group#_____

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Patient Name_____ Date of Birth_____

MEDICATIONS

Please list all medications you are currently taking (include prescriptions, over-the –counter meds and herbal supplements)

Medication Name **Dose** **How often do you take?**

_____
_____
_____
_____
_____
_____
_____

( ) see attached list

PLEASE LIST ALL PRIOR SURGERIES:

Type of Surgery Date Type of Surgery Date

_____
_____
_____
_____

SOCIAL HISTORY

Marital Status: ( ) Single ( ) Married ( )Partnered ( )Separated ( ) Divorced ( ) Widowed
Use of Alcohol: ( ) Never ( )No longer use ( )History of alcohol abuse
( ) Current Use- Type _____ ( )Rare ( )Occasional ( )Moderate ( ) Daily
Use of Tobacco Products: ( )Never ( )Quit- How long ago?_____
Type of tobacco product: _____ Smoke ___packs/day for ___ years
Use of Recreational Drugs: ( ) Never ( ) Current Use- Type _____
( )Rare ( )Occasional ( )Moderate ( ) Daily

FAMILY HISTORY (circle M: mother, F: father)

Diabetes Type 1 or 2 M F Cancer: M F Heart Disease: M F High Blood Pressure: M F
Stroke: M F Coronary Artery Disease: M F Bleeding Disorder: M F
Rheumatoid Arthritis: M F Alcohol /Drug Abuse: M F

Your Medical History

Allergies: ( ) Medications: _____
( ) Anesthesia: _____ ( ) Foods: _____
( ) Tape ( ) Latex ( ) Shellfish ( ) Iodine ( ) Other: _____
( ) None Known
Reaction: _____

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Patient Name_____ Date of Birth_____

Review Of Systems circle (N) no or (Y) yes

GENERAL, CONSTITUTIONAL
Recent weight loss N Y
Fever N Y
Chills N Y

EYES, VISION
Visual change N Y

EARS, NOSE, THROAT
Hearing loss N Y
Post Nasal Drip N Y

HEART CARDIOVASCULAR
Chest pain or pressure N Y
Arrhythmia or palpations N Y
Peripheral Edema N Y
Blood Clots N Y
Varicose Veins N Y
Cramping in legs N Y

RESPIRATORY
Cough N Y
Shortness of breath N Y
Wheezing N Y
Sleep Apnea N Y

GASTROINTESTINAL
Abdominal pain N Y
Heartburn N Y
Bloody Stool N Y
Ulcer history N Y

GENITOURINARY
Frequent urination N Y
Urgency N Y

MUSCULOSKELETAL
Joint pain or swelling N Y
Restricted motion N Y
Musculoskeletal pain N Y

SKIN
Rashes N Y
Sores/Ulcers N Y
Blisters N Y
Growths N Y

NEUROLOGICAL
Numbness/Tingling N Y
Sensation loss N Y
Burning N Y
Balance difficulties N Y

PSYCHIATRIC
Nervousness/Anxiety N Y
Depression N Y
Alcohol/Substance Abuse N Y
Known mental health disorder N Y _____

ENDOCRINE
Heat/Cold intolerance N Y
Excessive thirst N Y
Excessive urination N Y

HEMATOLOGICAL/LYMPATHIC
Abnormal bleeding N Y
Lymph edema N Y

ALLERGY/IMMUNOLOGICAL
Allergic Reactions N Y
Recurrent infections N Y
Immunological infectious disease N Y
Other N Y _____

Current Height: _____ Weight: _____ Shoe Size: _____Width: _____

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Patient Name_____ Date of Birth_____

Your Medical History Continued

PMH

Have You Ever Had Any Of The Following?

Acid Reflux	N Y	Kidney Disease	N Y
Anemia	N Y	Liver Disease	N Y
Arthritis	N Y	Low Blood pressure	N Y
Asthma	N Y	Migraine headache	N Y
Back trouble	N Y	Mitral valve prolapse	N Y
Bladder infections	N Y	Neuropathy	N Y
Abnormal Bleeding	N Y	Open sores(ulcers)	N Y
Blood clots	N Y	Pneumonia	N Y
Blood transfusion	N Y	Polio	N Y
Bronchitis/Emphysema	N Y	Rheumatic fever	N Y
Cancer	N Y	Sickle Cell Disease	N Y
Diabetes: Type I		Skin Disorders	N Y
or Type 2(circle)	N Y	Sleep Apnea	N Y
Fibromyalgia	N Y	Stomach Ulcers	N Y
Gout	N Y	Stroke	N Y
Heart Attack	N Y	Thyroid Disease	N Y
Heart Disease/Failure	N Y	Tuberculosis	N Y
Hepatitis	N Y	Other Conditions: _____	
HIV+/AIDS	N Y	_____	
High Blood Pressure	N Y		

CURRENT PROBLEM

What specific problem brings you to our office today?

_____

_____

How long ago did it start? _____Days/Weeks/Months/Years

Did you pain or problem: ( ) Begin all of a sudden ( )Gradually develop over time

How would you describe your pain or symptom?

( ) No pain ( ) Sharp ( )Dull ( )Achy ( )Burning ( )Radiating ( )Itching ( )Stabbing

( ) Other_____

Since the time your pain began, has it: ( )Stay the same ( )Become worse ( ) Improved

What makes the pain or problem worse? ( ) Walking ( )Standing ( ) Daily activities ( )Resting ( )Dress shoes ( )High Heels ( ) Flat shoes ( )Any closed tope shoe ( )Running ( )Other_____

What make your pain or problems feel better? _____

What treatments have you had for this problem? _____

Was this problem caused by injury? ( )Yes ( ) No (Describe) _____

If Yes, was it a work –related injury? ( ) Yes ( )No

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Patient Name_____ Date of Birth_____

Demographic Required of Governmental Statistical Analysis collection of this information is mandatory, practice will be fined if not collected

Race: ( ) American Indian or Alaska Native ( ) Asian ( ) Native Hawaiian ( ) Black or African American ( ) White ( ) Hispanic ( ) Non- Hispanic ( ) Other Pacific Islander ( ) Other Race ( ) I Decline to Report

Ethnicity: ( ) Hispanic ( ) Non- Hispanic ( ) I decline to report

Preferred Language: ( ) English ( ) Spanish ( ) Other

Do you have an Advanced Care Plan (Living Will)? Yes No (if you are 65 yo or older)
Have you had a Pneumonia Shot? Yes No (if you are 65 yo or older)

Have you had a Flu (Influenza) Shot? Yes No

I certify, to the best of my knowledge, I have answered all the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the Doctor and office staff of any and all changes in my medical status.

I give permission to the doctor at Central Arkansas Foot Care, A division of Joseph M. LaCava DPM, PA, to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patient/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, care taker or friend,over the age of 18 will be present; written consent form the parent or legal guardian stating as such must be presented at the time of the appointment. Thank you.

Patient Name: _____ (Print)
Patient /Guardian Signature:_____ Date: _____
Relation to signature: ( ) Self ( ) Parent/Guardian

HISTORY REVIEWED BY: JOSEPH M LACAVA DPM
Signature: _____ Date _____