



# FOOT CARE CENTERS OF PALM BEACH

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*ABPS Board Certified*

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10075 Jog Rd. Suite 208  
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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email: \_\_\_\_\_

Occupation \_\_\_\_\_ Name of Husband/Wife/Guardian \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Other Physicians involved in your healthcare: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Reason for you visit today: \_\_\_\_\_

Date of onset: \_\_\_\_\_

List any known allergies: \_\_\_\_\_

**MEDICATIONS: Please list current medications/dosage/frequency:**

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I authorize the release of medical information necessary to process this claim also payment to government benefits either to myself or to the party who accepts assignment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Habits:**

Alcohol:  None  Yes: How many drinks / day \_\_\_\_\_ frequency / week \_\_\_\_\_ What kind \_\_\_\_\_

Tobacco:  None  Yes: Chew or Smoke \_\_\_\_\_ How many / day \_\_\_\_\_ Since \_\_\_\_\_

Caffeine:  None  Yes: What kind \_\_\_\_\_ How many / day \_\_\_\_\_

**Family History** (Please indicate deceased or alive, medical issues and age):

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

**Past Surgical History (indicate date if known):**

- None
- Cataracts \_\_\_\_\_
- Tonsillectomy \_\_\_\_\_
- Thyroidectomy \_\_\_\_\_
- Adenoidectomy \_\_\_\_\_
- Coronary Bypass \_\_\_\_\_
- Cardiac Stents \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Heart Valve \_\_\_\_\_
- Gall Bladder \_\_\_\_\_
- Appendectomy \_\_\_\_\_
- Bowel / Stomach \_\_\_\_\_
- Hemorrhoidectomy \_\_\_\_\_
- Mastectomy \_\_\_\_\_
- Lumpectomy \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Bariatric \_\_\_\_\_
- Hysterectomy \_\_\_\_\_
- Endoscopy \_\_\_\_\_
- Colonoscopy \_\_\_\_\_
- Hernia \_\_\_\_\_
- Spinal \_\_\_\_\_
- Bladder \_\_\_\_\_
- Prostate \_\_\_\_\_
- Orthopedic / Joints \_\_\_\_\_
- Hip \_\_\_\_\_
- Knee \_\_\_\_\_
- Foot \_\_\_\_\_
- Cancer \_\_\_\_\_

**Past Medical History:**

|   |                              |                                       |             |
|---|------------------------------|---------------------------------------|-------------|
| Head Aches  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | Date: _____ |
| Stroke  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Seizures  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Diabetes (Type 1 or Type 2)                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Thyroid Disease (Low or High)                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| High Blood Pressure                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Blood Clots                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Pulm Emboli (lung clots) | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> DVT (leg clots)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Heart Burn, Reflux                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Stomach Ulcers                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Heart Disease                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Coronary Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> MI / Heart Attacks       | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Atrial Fibrillation      | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Angina                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Valve Disorder           | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| High Cholesterol                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Gastrointestinal Bleeding                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Hepatitis (A, B, C)                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Chronic Wounds                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Cancer (type)                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Incontinence                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Frequent Urination                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| COPD (Emphysema, Bronchitis)                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Asthma  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Depression  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Anxiety   | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Fibromyalgia                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Arthritis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Gout  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Osteoporosis                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Prostate Disease                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Breast Disease                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| Frequent Bowl Movement                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No           | _____       |
| <input type="checkbox"/> Mastectomy _____         |                              | <input type="checkbox"/> Cancer _____ |             |

**Review of Symptoms** ✓ Yes or Now for Symptoms in the Past 6 Months

**Circle** for Symptoms TODAY:

**Constitutional / Endocrine:**

- Yes  No Fever
- Yes  No Chills
- Yes  No Weakness / Fatigue
- Yes  No Weight Loss
- Yes  No Weight Gain
- Yes  No Insomnia
- Yes  No Snoring
- Yes  No Excessive Thirst
- Yes  No Excessive Urination
- Yes  No Cold or Heat Intolerance

Other: \_\_\_\_\_

**HEENT:**

- Yes  No Sore Throat
- Yes  No Stiff Neck
- Yes  No Change in Your Voice
- Yes  No Sinus Drainage
- Yes  No Sinus Head Ache
- Yes  No Nose Bleeds
- Yes  No Ear Ache / Drainage
- Yes  No Hearing Loss
- Yes  No Ringing in Your Ears
- Yes  No Blurred Vision / Loss
- Yes  No Wear Glasses or Contacts
- Yes  No Itchy / Watery Eyes
- Yes  No Dental Problems

Other: \_\_\_\_\_

**Gastrointestinal:**

- Yes  No Nausea / Vomiting
- Yes  No Difficulty Swallowing
- Yes  No Hemorrhoids
- Yes  No Diarrhea
- Yes  No Constipation
- Yes  No Bloody or Black Stools
- Yes  No Abdominal Pain
- Yes  No Heartburn / Indigestion
- Yes  No Frequent Use of Laxatives

Other: \_\_\_\_\_

**Urinary:**

- Yes  No Pain or Burning with Urination
- Yes  No Urinary Frequency (night or day)
- Yes  No Blood in Urine / Dark Urine
- Yes  No Incontinence
- Yes  No Slow Starting or Stopping Urine

Other: \_\_\_\_\_

**Cardiac:**

- Yes  No Chest Pain
- Yes  No Palpitation
- Yes  No Irregular Heartbeat
- Yes  No Exercise Intolerance
- Yes  No Leg Swelling

Other: \_\_\_\_\_

**Respiratory:**

- Yes  No Persistent Cough
- Yes  No Coughing Up Blood
- Yes  No Shortness of Breath
- Yes  No Wheezing
- Yes  No Can't Breathe Laying Flat

Other: \_\_\_\_\_

**Skin:**

- Yes  No Rashes / Hives
- Yes  No Skin Discoloration
- Yes  No Lesions / Moles / Warts
- Yes  No Ulcers
- Yes  No Itching
- Yes  No Nail Problems
- Yes  No Unusual Hair Loss
- Yes  No Easy Bruising

Other: \_\_\_\_\_

**Psych:**

- Yes  No Depressed Mood
- Yes  No Suicidal Thoughts / Plans
- Yes  No Agitation / Irritability
- Yes  No Insomnia
- Yes  No Anxiety
- Yes  No Frequent Crying Spells

Other: \_\_\_\_\_

**Musculoskeletal:**

- Yes  No Joint Pains or Stiffness
- Yes  No Joint Swelling
- Yes  No Muscle Weakness
- Yes  No Back Pain
- Yes  No Muscle Spasms / Cramps
- Yes  No Falling

Other: \_\_\_\_\_

**Neurologic:**

- Yes  No Frequent Headache
- Yes  No Seizures
- Yes  No Syncope (passing out)
- Yes  No Limb Weakness
- Yes  No Limb Numbness
- Yes  No Dizziness
- Yes  No Swallowing Difficulty
- Yes  No Balance Issues
- Yes  No Tremors
- Yes  No Rigidity

Other: \_\_\_\_\_

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**CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I understand that if I want to receive treatment from one or more of the health care providers, ("Providers") associated with this Practice; I need to give permission for them to share information about my health, among themselves and with other individuals for treatment, billing purposes and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of the method by which it is communicated.

By signing below, I agree that any of the Providers associated with this practice may:

1. Use my health information, on a need to know basis, to give me treatment.
2. Share my health information with others who are involved with my treatment either in or outside of this practice.
3. Use my health information for billing purposes.
4. Share my health information with health insurance companies, government agencies, or other payors that request information related to benefits, claims filed, and other billing matters.
5. Share my health information either in or outside of this practice for health care operations that include evaluation of the quality of health care services your receive, and of the performance of the Providers to find better ways to provide care.
6. Share my health information with outside parties ("Business Associates") who contract with the practice to perform medical services on behalf of our patients. (ie: lab, radiology, night nurse triage, or for nebulizer equipment release)

Additionally, the Practice will generate Health Assessment Forms at annual physical examinations which provide information on current health and immunization status. These Forms will be given to me for my personal use and any further disclosure of this information I choose to make is at my personal discretion.

I understand that the Practice has a "Notice of Privacy Practices" ("Notice") that describes in detail (1) how my health care information is used and shared, (2) when I need to give further approval for the Providers to use and share my health information, (3) when my permission is not needed for the Providers to use and share my health information, (4) my rights regarding my health care information, and (5) grievance procedures if I believe my privacy rights have been violated. I understand that I may request restrictions on the uses and disclosures of my health information. The Practice is not legally required to accept my request, but if it does, it will put any such restrictions in writing and abide by them except in emergency situations, or where required by law.

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this Consent. I understand that Foot Care Centers of Palm Beach reserves the right to change the Notice at any time. I may obtain a current copy of the Notice by contacting the Practice at (561) 734-4876.

I understand that I may revoke this consent, in writing, except to the extent that the Providers have already acted on it. I also understand that if I revoke this consent, the Providers have the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my health information as described above.

Signature of Patient or Legal Guardian \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_