Name: _____
Date of birth: _____

Podiatry Issues: (Why are you being seen?): _____

Have you been hospitalized in the last 2 years? Yes☐ No☐ (If yes, please describe) _____

Past surgeries: including foot surgeries
_____
_____
_____

Medications: (dosage, strength)
_____
_____
_____

Height: _____
Weight: _____
Shoe size: _____

CONSENT FOR RX HUB INQUIRY

I hereby provide my consent for the practice to obtain my Rx history using the Sure Scripts – Rx Hub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that the SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPPA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to system communications.

SIGNATURE: _____ DATE: _____

If you are a diabetic what was your last hemoglobin A1C value? _____

Pharmacy Name: _____ Address: _____ City & State _____

Allergies: (check only ones that apply) - ☐ None
☐ Aspirin ☐ Sulfa ☐ Latex ☐ Codeine ☐ Novocain/lidocaine ☐ Penicillin
☐ Iodine ☐ Adhesive tape Other _____

Illnesses and chronic conditions: Do you or any of your family member(s) have any of the following:

	Patient	Father	Mother	Grandfather F	Grandfather M	Grandmother F	Grandmother M	Sibling
Diabetes								
Neurologic								
Foot deformities								
Toenail problems								
Bunion(s)								
Hammer toe(s)								
DECEASED								
ALIVE								

If your family history is unknown please check here: ☐

Do you have any of the following conditions?

	Yes	No	Specify
Vision Problems			
High Blood Pressure			
Heart Problems			
Lung Problems			
Liver Problems			
Diabetes			
Kidney Problems			
Back Problems			
Joint Problems			
Skin Disorders			
Stroke			
Other Nerve Disorders			
Psychiatric Diagnosis			
Anemia			

Social History: Are you a:
__ Never Smoker
__ Current Smoker: Do you smoke everyday? ___ How many packs per day? ___ When did you start smoking? ___
Are you interested in quitting? ____
___Former Smoker: When did you start smoking? ___ When did you quit smoking? _____

Have you had an alcoholic beverage in the last 12 months? ___Yes ___No
How often do you drink: ___Monthly _____2-4 times a month ___2-3 times a month ___4+times a week
How many drinks did you have on a typical day when drinking? _____

Have you had 2 or more falls in the last year? Yes□ No□
Describe any injury: _____
Have you had 1 fall with injury? Yes□ No□
Describe the injury: _____

Your preferred language is: English□ Spanish□ French□ Italian□ Chinese□ Portuguese□ Other□
Race/Ethnicity: Caucasian (White) □ African American/Black□ Hispanic□ Indian□ Asian□ Other□

Are you employed? Yes□ No□ Place of employment: _____ Occupation: _____
Does your job require you to stand for long periods of time? Yes□ No□ How Long? _____
With whom do you live? _____

Is this office visit due to any of the following:
Injured while on the job: YES □ NO □ **Auto Accident**: YES □ NO □ **Personal Injury:** YES □ NO □
If you answered YES to any of the above, please ask the receptionist for a Worker's Compensation Form to complete.

IS THE PATIENT RESPONSIBLE FOR PAYMENT? YES ____ NO____
IF NO, PLEASE COMPLETE:
Name of Responsible Party: _____ Relationship: _____
Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____
I also authorize treatment to myself and/or my child (or dependent if you are the guardian).

IN CASE OF EMERGENCY PLEASE CONTACT:
Name: _____ Phone: _____ Relationship: _____

•I authorize Methuen Podiatry Associates to release all information for filing insurance claim(s).
•If my insurance requires a referral it **is** my responsibility and I am responsible for payment if it **is** not obtained.
•I authorize Methuen Podiatry to obtain medical information from other physicians for the continuity of my care.
•I have received a copy of the financial policy for Methuen Podiatry.

I acknowledge that I have been offered a copy of the Privacy Practice notice made available to me in office or online at Methuenpodiatry.com/privacy-policy to read and review.

SIGNATURE: _____ DATE: _____
PRINT NAME: _____
Name of person completing this form: _____
Relationship: (if other than patient) _____