ARLINGTON / MANSFIELD
Foot & Ankle Centers
Part of StrideCare

HEALTH QUESTIONNAIRE
PLEASE PRINT CLEARLY

Last Name: _____First Name: _____
Height: _____Weight: _____Gender: _____DOB: _____Age: ____
Family Doctor Name: _____Date of Last Visit: _____City: _____
YOUR OCCUPATION: _____ Who referred you here? _____
Reason for Visit: _____
Pharmacy and Phone Number: _____

Medication Allergies: _____
Medication List (including non-prescription)

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

Personal Medical History: Have you ever had (circle all that apply) NONE

Diabetes	Depression/Anxiety
High Blood Pressure	Epilepsy/Seizures/Stroke
Heart Disease/Heart Attack	Arthritis (type)
Bleeding Disorders	Gout
Phlebitis/Blood Clots/DVT	Tumors or Cancer (type)
Any Kidney Disease	HIV Exposure
Any Liver Disease/Hepatitis	Injury to Feet, Ankles, Legs or Back
Asthma/COPD/Emphysema	Hypothyroidism
Stomach/Ulcer/Colitis/GERD	Other:
Neuropathy	

Surgical and Hospitalization History: (List all with year and any complications) None

1.	4.
2.	5.
3.	6.

Social History:

Are you pregnant? Yes or No	Do you drink alcohol? Yes or No
Do you smoke? Yes or No	If yes – social moderate frequent
Do you use other tobacco? Yes or No	Last Tetanus Vaccine Date: _____
Do you vape? Yes or No	Pneumococcal Vaccine Date: _____

_____

Family History: Please circle all that apply and note relation:

Diabetes	
Hypertension (High Blood Pressure)	
Heart Disease	

Please ask if you have any questions about this form. This will ensure the safest and most effective care possible

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Today's Date: _____

Patient Name: _____ Date of birth: _____

Gender: _____ Marital Status: M S D W

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Can we text you? Yes or No

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Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Pharmacy name and phone number: _____

How did you hear about our office? _____

Reason for visit: _____

PCP and last date seen: _____

Insurance Information: (Please present cards to receptionist)

Primary Insurance Company Name: _____

Insurance ID: _____ Policy Holder Name: _____

Secondary Insurance Company Name: _____

Insurance ID: _____ Policy Holder Name: _____

Payment for office visits and procedures is due at the time of service unless prior arrangements have been made. Patients/guarantors are responsible for deductible and co-insurance amounts.

Signed _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENTS FOR USE AND DISCLOSURE

_____ I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which AMFAC may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures of this information. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my personal health information (PHI) for the purpose treatment, payment and healthcare operations (TPO) described in the Notice of Privacy Practice.

_____ In accordance with Texas law, this practice discloses that the physicians of AMFAC may have ownership interest in a surgical facility (Baylor Surgicare Mansfield 260 Regency Park Mansfield, TX 76063) that is used in providing your care. However, please be assured that decisions and recommendations are made with the utmost concern for what is most appropriate and to ensure the best possible outcome for you as a patient.

_____ I consent to receive communications by call, text, mail or email from AMFAC for purposes of carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance inquiries, billing statements and/or medical information, etc.

_____ I authorize payment of medical benefits to Arlington Mansfield Foot and Ankle for services rendered

_____ I authorize the physicians at Arlington Mansfield Foot and Ankle to treat my condition medically, surgically and orthopedically.

Voicemail Messages - Would you prefer to receive a detailed or brief message left on your voicemail when we aren't able to reach you? Please circle one: **Detailed** **Brief**

Email Address - _____

RELEASE OF PERSONAL HEALTH INFORMATION

I authorize AMFAC to disclose my protected health/billing information (PHI) to the following people listed below. This authorization allows AMFAC to disclose ALL medical/billing information to the people listed below unless stated otherwise. I understand that I can add or delete people at any time and must be done in writing, signed and dated.

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____

By signing this form, I give consent to Arlington/Mansfield Foot & Ankle Centers to use and disclose my PHI to carry out TPO. I may revoke this consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior written consent. If I do not sign this consent, or later revoke it, AMFAC may decline to provide services to me.

_____ _____ _____

Signature of patient or representative Relationship Date

StrideCare

Your doctor is a member of StrideCare, a multi-specialty network of providers focused on delivering comprehensive lower extremity care. Below you will find important questions that will help us determine whether you are at risk for vascular disease and might benefit from early detection and treatment options.

Please take a moment to answer the questions below:

Have you ever had any testing done to your legs for poor circulation?	☐ YES	☐NO
RISK FACTORS		
Have you ever been told you have diabetes?	☐ YES	☐NO
Do you have high blood pressure or are you on blood pressure medication?	☐ YES	☐NO
Do you have high cholesterol or are you on a medication to lower your cholesterol?	☐ YES	☐NO
Do you smoke or have you ever smoked?	☐ YES	☐NO
Have you ever been told that you have had a heart attack or stroke?	☐ YES	☐NO
Has anyone ever told you that you have poor circulation in your legs, intermittent Claudication (pain with activity that improves with rest) or peripheral arterial disease?	☐ YES	☐NO
Have you ever had an angioplasty or stent placed in the heart or leg?	☐ YES	☐NO
SYMPTOMS OF Arterial Conditions		
Do you have any infections or sores that are not healing on your legs, feet or toes?	☐ YES	☐NO
Has your walking pace slowed enough to significantly alter your daily activities?	☐ YES	☐NO
Do your legs ever feel tired or heavy causing you to stop and rest? Do they get better with rest?	☐ YES	☐NO
When you walk, do you ever have to stop because you have pain or cramping in your calves, thighs, or buttocks? Does the pain go away with rest?	☐ YES	☐NO
Do you ever experience cramping, tightness, "Charlie horses" or pain in the legs or feet when lying down that improves when you stand up?	☐ YES	☐NO
Have you given up things you once enjoyed doing over the last year due to leg fatigue, weakness, or discomfort?	☐ YES	☐NO
Have you ever had trauma to either of your legs?	☐ YES	☐NO
Do you have any infections or sores that are not healing on your legs, feet or toes?	☐ YES	☐NO
SYMPTOMS OF Venous Conditions		
Do you have aching/pain in your legs?	☐ YES	☐NO
Do you get cramps in your legs?	☐ YES	☐NO
Do your legs feel heavy?	☐ YES	☐NO
Do you get itching or burning in your legs?	☐ YES	☐NO
Do you have restless legs?	☐ YES	☐NO
Discoloration/darkening of the skin below your knee?	☐ YES	☐NO
Episodes of redness or inflammation below the knee?	☐ YES	☐NO
Do you have swelling in your legs, ankles, or feet?	☐ YES	☐NO
Throbbing in your legs?	☐ YES	☐NO
Do your legs feel tired/fatigued?	☐ YES	☐NO
Do you have varicose veins or spider veins?	☐ YES	☐NO
Sores, ulcers, wounds that are difficult to heal?	☐ YES	☐NO
At StrideCare we deeply value our patients and want to provide you excellent service. Would you give us permission to contact you to discuss your vascular health and options for lower extremity care?	☐ YES	☐NO