FIRST STEP
FOOT & ANKLE CENTER

Medical Office Building 1
18400 Katy Freeway, Suite 590
Houston, TX 77094

Telephone: (281) 910-7172
Fax: (281) 503-7812

NEW PATIENT IN-TAKE FORM

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ Sex [ ] M [ ] F

Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ Zip _____

Please provide a copy of your insurance card to our staff.

Primary Insurance: _____ Subscriber ID: _____ Group #: _____

Secondary Insurance: _____ Subscriber ID: _____ Group #: _____

Who can we thank for referring you/ how did you find us? _____

Family Physician _____ City _____ Date of Last Visit _____

Pharmacy _____ City _____ Phone #: _____

Height _____ Weight _____ Shoe Size _____

PHONE NUMBERS

Home Phone _____ Cell Phone _____

Email _____

In case of emergency, please contact:

Name _____ Phone _____ Relationship: _____

EMPLOYMENT

Name of Employer _____ City _____

At your job do you: [ ] Mostly sit [ ] Mostly stand [ ] Sit and Stand

Are you required to wear a specific type of shoe/boot? _____

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REVIEW OF SYSTEMS	*Please check all that apply*
NERVE	[ ] Foot Burning [ ] Foot Numbness [ ] Seizure [ ] Loss of Balance
SKIN	[ ] Rash [ ] Skin Sores [ ] Itching [ ] Dry Skin [ ] Toenail Changes
ORTHOPEDIC	[ ] Joint Pain [ ] Muscle Pain [ ] Leg Cramps [ ] Weakness [ ] Knee Pain [ ] Back Pain

REASON FOR VISIT

Reason for today's visit _____ How Long? _____

Severity of Pain or condition: [ ] Mild [ ] Moderate [ ] Severe [ ] Severe at times

Pain scale: (1-10) _____

Type of pain (if painful): [ ]Sharp [ ]Dull [ ]Stabbing [ ]Aching [ ]Burning [ ]Other _____

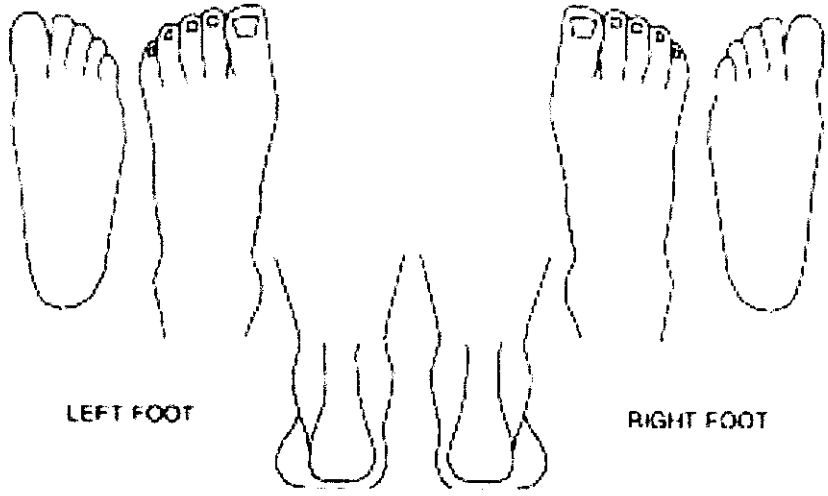
This problem is: [ ] Improving [ ] Worsening [ ] Unchanged

What makes it worse: [ ]Activity [ ]Exercise [ ]Work [ ]Laying in Bed [ ]Other _____

What makes it better: [ ] Rest [ ] Ice [ ] Heat [ ] Elevation [ ] Other _____

What treatments have you tried, if any _____

Indicate area of concern:



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MEDICAL HISTORY

[ ] AIDS / HIV	[ ] Heart Trouble	[ ] Gout
[ ] Diabetes (Insulin)	[ ] Kidney Disease	[ ] Fibromyalgia
[ ] Diabetes (No Insulin)	[ ] Lung Disease (COPD)	[ ] Blood Clots
[ ] Arthritis	[ ] Hepatitis A, B, C	[ ] Artificial Joints
[ ] High Blood Pressure	[ ] Stomach Problems	[ ] Cancer: _____
[ ] Stroke (CVA)	[ ] Anxiety/Depression	

SOCIAL HISTORY / FAMILY HISTORY

Do you smoke tobacco? [ ] Yes [ ] No If yes, how many packs per day? _____

If no, did you smoke in the past? [ ] Yes [ ] No If yes, how many years did you smoke? _____

Do you drink alcohol? [ ] No [ ] Occasional [ ] Moderate [ ] Heavy

Circle all that apply - Family History of: Diabetes, Gout, Flat Feet, Ingrown Toenails, Bunions

MEDICATIONS: *List all medications*

_____ Dosage: _____	_____ Dosage: _____
_____ Dosage: _____	_____ Dosage: _____
_____ Dosage: _____	_____ Dosage: _____

ALLERGIES: *Please specify reaction*

[ ] Latex – reaction: _____ [ ] Tape – reaction: _____ [ ] Iodine – Reaction: _____

[ ] Shellfish – reaction: _____ [ ] Other: _____ - reaction: _____

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CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature/Responsible Party: _____ Date_____

Patient's Printed Name/Responsible Party: _____ Date_____

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