High Plains Podiatry

WELCOME TO OUR PRACTICE!

We realize that long questionnaires for simple problems may be considered time consuming and unnecessary. We sincerely apologize. Every question, however, may have a serious medical consequence if not answered. If you choose not to answer a question, please just initial the question.

Please take your time in answering them fully. Thank you.

Patient Name_____ Date_____

Family Physician_____ Last Visit_____

PLEASE DESCRIBE YOUR PROBLEM. INCLUDE WHEN IT BEGAN, WHAT MAKES IT WORSE AND BETTER, ANY TRAUMA OR INJURY, AND ANY TREATMENT BY A DOCTOR OR YOURSELF.

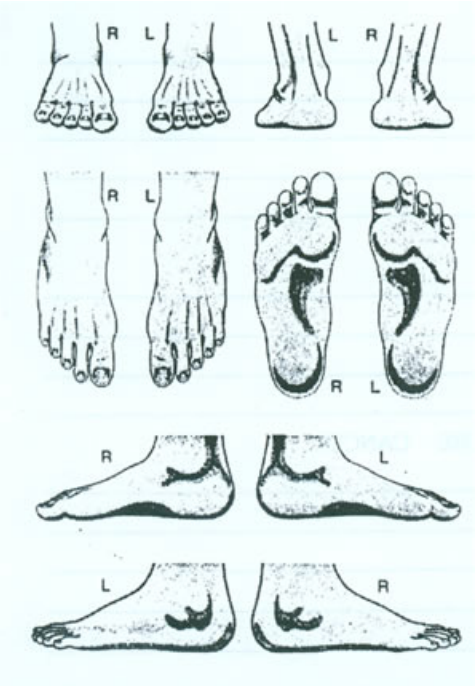
_____

_____

_____

_____

On the diagram below, please mark the place(s) you are experiencing pain in your feet:



DEGREE OF PAIN: MILD MODERATE SEVERE

TYPE OF PAIN: THROBING BURNING STABBING
ACHING RADIATING OTHER_____

DURATION OF PAIN: CONSTANT USUALLY OCCASIONAL
OFF/ON

TIME OF DAY: MORNING AFTERNOON EVENING NIGHT
AFTER WORK

SHOE GEAR: BOOT STEEL TOE SNEAKERS HEELS
OTHER_____

WALKING/STANDING

AT WORK: NEVER SOMETIMES USUALLY ALWAYS

AT HOME: NEVER SOMETIMES USUALLY ALWAYS

PLEASE CONTINUE ON FOLLOWING PAGE

PLEASE CIRCLE ANYTHING THAT APPLIES TO YOU.
WRITE ADDITIONAL INFORMATION AT SPACE PROVIDED AT THE END OF THE PAGE.

YOU SMOKE: NEVER QUIT ____ YEARS AGO YES____PCKS PER DAY

YOU DRINK: NEVER SOCIALLY EVERY DAY RECOVERING

GENERAL: ANY RECENT WEIGHT CHANGE FEVER CHILLS WEAKNESS NAUSEA VOMITING DIARRHEA

RESPIRATORY: ASTHMA EPHYSEMA BRONCHITIS SHORTNESS OF BREATH
OTHER RESPIRATORY_____ NO IISTORY

HEART: CHEST PAIN HEART ATTACK ANGINA OTHER HEART PROBLEMS_____ NO HISTORY

ABDOMEN: KIDNEY DISEASE LIVER DISEASE STOMACH ULCERS
HEPATITIS PROBLEMS TAKING ASPRIN NO HISTORY

BLOOD/CIRCULATION: ANEMEA EASY BRUISING BLEEDING PROBLEMS TRANSFUSIONS NO HISTORY

HOW FAR CAN YOU WALK WITHOUT STOPPING? <5BLOCKS >5 BLOCKS

JOINTS: JOINT PAIN /REDNESS /SWELLING WHAT JOINTS?_____
_____
OSTEOARTHRITIS DEGENERATIVE ARTHRITIS RHEUMATOID
GOUT OTHER ARTHRITIS_____ NO HISTORY

NEUROLOGICAL: SEIZURES LOSS OF CONSCIOUSNESS NUMBNESS/TINGLING
PARALYSIS PSYCHIATRIC TREATMENT NO HISTORY

GENERAL: DIABETES HEAT/COLD INTOLERANCE HIGH BLOOD PRESSURE
CANCER MIGHT YOU BE PREGNANT? ____YES ____NO

medications and amount (include aspirin, birth control)

_____

_____

_____

allergies (include hayfever, any medications, aspirin, etc.) _____

_____

hospitalization/surgeries (date/problem/complications)_____

_____

_____

last tetanus immunization_____

ANY FAMILY HISTORY OF: DIABETES HIGH BLOOD PRESSURE CANCER
AND OTHER HEALTH OR MEDICAL CONDITION_____

_____

_____

_____

High Plains Podiatry

Patient Information

Date_____

Patient Name_____ Sex: M F Birthdate_____ Age_____

Address _____ City_____ Zip_____

Cell Phone ( )_____ Home Phone ( )_____ Work Phone ( )_____

Social Security Number_____ Employed by_____

Work address _____ Occupation_____

Contact in case of emergency_____Relationship_____ Phone No_____

Referred to our office by_____ Family Physician_____

Insured's Name/Responsible Party_____Relationship_____

Address and Phone (if different)_____

Insured's Employer_____ Insured's Occupation_____

Health Insurance_____

I am aware that all charges are due and payable at the time of each visit. I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim.

SIGNATURE_____

YOUR PRIVACY AND OUR OFFICE

This sheet is a requirement of the U.S. Government.

You have a right to keep your medical information private. For your privacy and protection you medical information will only be released to:

1. Your spouse, guardian or parent (if you are a minor
2. Your primary care physician, physician assistant, nurse practitioner or other health care practitioners involved in your care.
3. Any health care facility such as a hospital, laboratory physical therapy office that may be involved in your care.
4. Your insurance carrier.

If you choose not to have medical information released to any of the above you must request this in writing.

Phone calls are a difficult problem to reconcile with privacy. This is because people can misrepresent themselves or their needs. For instance, if you are having a question on billing/insurance or you medical condition, you may want the convenience of making a phone call. However, it is virtually impossible for our staff to reasonably or accurately determine who is actually making the call.

Dr. Cettie and his staff will engage in phone conversations with anyone who represents themselves as:

- The patient
- spouse
- parent
- guardian

If we have need to contact you, Dr. Cettie and his office staff will call and leave messages at the numbers you provide to us.

If you choose to change or modify this release, you must request this in writing.

I have read and understand Dr. Mark Cettie's privacy policy.

PATIENT SIGNATURE_____DATE_____

PRINT NAME OF PATIENT_____