TBSMC
Tampa Bay Sports Medicine Center

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FOOT & ANKLE CARE
DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY

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PATIENT INFORMATION

Name: _____ **DOB:** _____ **SS#:** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered

E-mail: _____ **Spouse/Partner Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____ **Leave Message?** ☐ **Y** ☐ **N**

Employer: _____ **Your Occupation:** _____ **Work #** _____

Emergency Contact: _____ **Home #** _____ **Cell #** _____ **Relationship** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Other Physician: _____ Phone: _____ Date Last Seen: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend

Whom may we thank for referring you? _____

INSURANCE

Primary Insurance Name: _____ Are you the insured? ☐ Yes ☐ No

Subscriber or Member ID: _____

Primary Holder's Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone #: _____ Sex: ☐ Male ☐ Female DOB: ___/___/___

PODIATRIC HISTORY

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐ Yes ☐ No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling Other _____

Have you ever been to a Podiatrist before? ☐ **Yes** ☐ **No**

Name _____ **Last Visit** _____

MEDICAL HISTORY

Medical History: ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeltal ☐ Breathing issues
☐ Liver disease ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy (specify) _____ ☐ Thyroid disease (specify) _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis (specify) _____ ☐ Other (specify) _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke
Surgical History: ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ If yes how many packs per day ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long? _____
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

CURRENT MEDICATIONS

☐ No Known Medications ☐ I take the following medications:
Name: _____
_____
_____
_____
_____
_____
_____

ALLERGIES

☐ No Known Allergies ☐ No Known Drug Allergies:
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____
Name: _____ Reaction _____

REVIEW OF SYSTEMS

(Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	☐ leg pain when walking ☐ fainting	☐ fever ☐ palpitations	☐ chest pain/pressure ☐ vascular disease	☐ leg swelling ☐ valve problems	☐ cold hands/feet ☐ **NONE**
Genitourinary	☐ blood in urine ☐ decreased frequency	☐ hesitancy ☐ excessive urination	☐ incontinence ☐ kidney disease	☐ increased urgency ☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain ☐ diarrhea	☐ hearburn ☐ trouble swallowing	☐ blood in stool ☐ decreased appetite	☐ vomiting ☐ increased appetite	☐ ulcers constipation ☐ **NONE**
Neurological	☐ tingling ☐ tremors	☐ weakness ☐ paralysis	☐ seizures	☐ numbness	☐ headaches ☐ **NONE**
Respiratory	☐ chest pain ☐ shortness of breath	☐ wheezing ☐ emphysema	☐ COPD	☐ coughing	☐ snoring ☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ low leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Musculoskeletal	☐ back pain ☐ sciatica	☐ joint swelling ☐ joint stiffnes	☐ muscle weakness ☐ joint pain	☐ joint instability	☐ muscle pain ☐ arthritis ☐ neck pain ☐ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient