WELCOME TO THE OFFICE OF STEPHANIE CAROLLO, DPM

Patient Name:_____DOB:_____ Age:_____

Address: _____

City: _____State: _____ Zip:_____

Cell Phone:_____ Home :_____ Work:_____

Email Address: _____

(Note: We will not share your email address.)

Social Security Number: _____

Marital Status: S, M, W, D, prefer not to specify

Emergency Contact Name:_____ Phone(s):_____

Family Physician/Internist:_____ Phone:_____

Pharmacy: _____ Pharmacy Phone: _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Insurance Company Name: Primary Insurance _____

Insurance Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance: _____ Subscriber Name & DOB: _____

Responsible Party (if other than patient) Name & DOB: _____

Responsible party's address (if different): _____

Do you have an HMO insurance? Yes No **If yes, you must have your referral or your appointment will need to be rescheduled.**

I authorize Dr. Stephanie Carollo / Tender Foot and Ankle Care PLLC to release any medical information necessary to process my insurance claim, and I authorize payment of medical benefits to be made to this practice for services rendered. I agree to pay all of my co-pays, coinsurance, deductibles, and any balance that is denied or in dispute by my insurance company.

SIGNATURE: _____ DATE: _____

Patient, parent, or responsible party

MEDICAL HISTORY

Anemia Y N	Congestive heart failure (CHF) Y N	Head injury Y N	scoliosis Y N
Asthma Y N	Diabetes Y N	high blood pressure Y N	seizures Y N
Arthritis (osteo) Y N	emphysema Y N	kidney problems Y N	stroke Y N
Blood clots Y N	epilepsy Y N	liver disease Y N	thyroid problem Y N
Blood transfusion Y N	fibromyalgia Y N	multiple sclerosis Y N	tuberculosis Y N
Cancer Y N	heart attack Y N	paralysis Y N	foot/skin ulcers Y N
Cholesterol Y N	heart catheterization Y N	polio Y N	weakness Y N
	Hepatitis A / B / C Y N	stomach/intestinal ulcer/bleeding Y N	RA Y N

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE? (Please list) _____

ALLERGIES: do you have any allergies to any medications? No **Yes:** please list _____

SURGICAL HISTORY: _____

_____

MEDICATIONS: please **list all of your medications, including OTC and herbal, etc.:**

_____

_____

SOCIAL HISTORY: Is there any chance that you could be pregnant? Y N If female, date of LMP: _____

Do you smoke? Y N If yes, how much? _____per day For how long? _____Have you quit smoking? Y N

Do you drink alcohol? Y N If yes, how much/how often? _____

Do you use any recreational drugs? Y N If yes, what type? _____

Do you use any assisted devices? ___cane ___walker ___wheelchair ___crutches

Occupation: _____ Are you currently working? Y N Reason not working: _____

Height: ____ ft ____inches Weight: _____lbs. Shoe size? _____

FAMILY History: please indicate any condition(s) that your FAMILY has:

Diabetes Y N blood clots Y N blood disorder Y N heart disease Y N cancer Y N

Other FAMILY medical problems not listed above:_____

CHIEF COMPLAINT: what is the reason that prompted you to make this appointment?

_____

_____

How long has this problem/symptom(s) been present? _____

Have you tried or received any prior treatment for this condition? No Yes, please explain:

_____

Do you now or have you recently had any problems related to the following systems? Circle YES or NO. If you mark YES to any of the following, please indicate next to that problem the doctor that is treating you. **If you haven't seen a physician yet, please contact your Internist or Family Physician to address these issues.**

Cardiovascular

chest pain (recent) Y N
irregular heartbeat Y N
large varicose veins Y N

Hematological/Lymphatic

swollen glands Y N
blood clotting problem Y N

Endocrine

excessive appetite Y N
excessive thirst Y N

Constitutional Systems

fever Y N
chills Y N
excessive fatigue Y N

Gastrointestional

abdominal pain Y N
heartburn Y N
vomiting Y N

Psychological

Do you suffer from depression? Y N
Do you feel severely anxious or nervous? Y N

Neurological

numbness/tingling Y N
seizures Y N
tremors Y N
paralysis Y N

Musculoskeletal

neck pain Y N
hip pain Y N
back pain Y N
knee pain Y N
shoulder/elbow/hand pain Y N

Integumentary

skin rash Y N
persistent boils Y N
persistent skin itch Y N

Respiratory

wheezing Y N
frequent shortness of breath Y N

Patient Name (Printed): _____

Patient Signature_____ Date:_____