Practice: DAVID A SIMONSON, DPM PA **Today's Date:**

Name: ______________________ **DOB:** ____________ **Chart Number:** ____________

Sex: ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** ______________

E-mail: ______________________ **Spouse/Partner Name:** ______________

E-mail newsletters, reminders, statements, etc. **Emergency Name:** ______________ **Phone:** ____________

Address: ______________________ **City:** ____________ **State:** ______ **Zip:** ________

Home #: ______________ **Cell #:** ______________ **Other #:** ______________

Employer: ______________________ **Phone:** ______________

Employer Address: ______________________ **City:** ____________ **State:** ______ **Zip:** ________

Primary Insurance: ______________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: ______________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

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

Address: ______________________

Policy ID: ____________ Group ID: ____________ Employer: ____________

Secondary Insurance: ______________________ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: ______________ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

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

Address: ______________________

Policy ID: ____________ Group ID: ____________ Employer: ____________

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

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: __________

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: ______________

Rev 6/5/2012

History and Physical

Name: ______________________ **DOB:** _________ **Chart Number:** _____

Medical History: ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ 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: __________
☐Yes, I had a past 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: __________

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)* mother/father only.

☐ Alzheimer's	______	☐ Depression	______
☐ Arthritis	______	☐ Diabetes	______
☐ Bleeding disorders	______	☐ Emphysema	______
☐ Blood clot	______	☐ Heart disease	______
☐ Cancer	______	☐ High Blood Pressure	______
☐ Cataracts	______	☐ Neurological	______
☐ Circulation problems	______	☐ Strokes	______
☐ Other (specify):	______		

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

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

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Patient Signature: ______________________ Date: __________