Podiatry Specialists of Iowa
FOR ALL YOUR FOOT CARE NEEDS

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PH: 319-294-3668	PH: 319-283-1373	PH: 319-294-3668	PH: 319-294-3668
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Patient's Name_____ Age_____ Birth Date_____

Home Address_____

City: _____State:_____ Zip Code: _____

Home Phone _____ Cell Phone _____ E-mail _____

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widow/er ( ) Minor Sex: ( )Male ( )Female

SS #_____ Parent name (if under 18):_____

Employed By_____ How Long?_____ Occupation_____

Work Address_____

City_____ Zip Code _____ Work Phone_____

PATIENT STATS: Height_____ Weight_____ Shoe Size_____

If 60 or older: Have you have a fall in the last year? Y/N Do you worry about falling? Y/N

Are you Diabetic? Y/N IF YES, who do you see for Diabetic care? _____

****Diabetic patients are required to provide a date last seen by care doctor every six months for insurance claims.**

SOCIAL HISTORY

Pregnancy: Are you pregnant? [] No [] Yes _____

Tobacco History: [] No [] Yes - Packs per day ____ How many years? ____ When did you quit? _____

Alcohol History: [ ]No [ ]Yes - How often and how much each week _____

Recreation Drugs: [ ]No [ ]Yes _____

Job Description: Describe work activities _____

Exercise: Describe type and frequency _____

Vaccinations: Influenza: Y/N Pneumonia: Y/N Covid: Y/N

CURRENT ALLERGIES: Please list any reactions to any medications, tapes, soaps, latex rubber, or other substances.

_____

[] I am PENICILLIN ALLERGIC; it causes [] Hives [] Shortness of breath [] Anaphylaxis reactions.

[] Other Allergies _____

**** Do you give us consent to request prescription history? Y/N**

(If yes, you do not need to complete medication list unless list is unable to be transmitted. You may also provide a meds list for us to copy)

CURRENT MEDICATIONS: List the type and dosage of all medications including aspirin, birth control, herbs, and vitamins.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICAL HISTORY:

Check off any condition that has been treated in the past?

[ ] Diabetes, [ ] Diabetic Foot Ulcers, [ ] Neuropathy (Nerve Pain/Problems), [ ] Thyroid, [ ] Active Infection, [ ] Blood Thinners,[ ] Chronic Pain Management, [ ] Restless Leg Syndrome, [ ] Fibromyalgia, [ ] Mental Illness [ ] Gout [ ]AIDS / HIV Positivity, [ ]Hepatitis, [ ]Heart Attack, [ ] Heart Murmurs, [ ] Irregular Heart Beat, [ ]Mitral Valve Prolapse, [ ] Rheumatic Fever, [ ] Congestive Heart Failure, [ ] Hypertension, [ ] Stroke, [ ] Convulsions, [ ] Seizures, [ ] Cancer, [ ] Asthma, [ ] Emphysema, [ ] Rheumatoid Arthritis, [ ] Bleeding problems, [ ] Sickle-cell Disease, [ ] Blood Transfusions, [ ] Prior Injury to lower extremity (Please specify:_____).

Do you have any artificial joints? Y/N If yes, please list: _____

Do you have a pacemaker? Y/N

Do you have an artificial heart valve? Y/N

PAST ILLNESS, INJURY OR SURGICAL HISTORY: Please list all major illnesses, injuries, hospitalizations and operations:

_____

_____

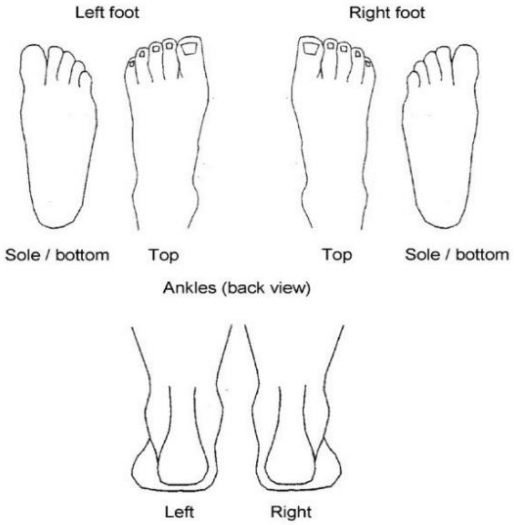
_____

CHIEF COMPLAINT AND ITS HISTORY:

Please describe what is wrong, when did the problem begin, its location, and how has it progressed:

_____

_____



Quality of Pain: [] Burning [] Throbbing [] Sharp [] Dull

[] Dull or [] Aching [] Constant [] Shooting

Severity:1 to 10 scale -- 10 as unbearable? _____

Duration and Timing of the pain?

_____

_____

What causes the pain to decrease or increase?

_____

_____

Any prior history of injury to foot/ankle? _____

_____

Do you wear a brace or orthotics? _____

REVIEW OF SYSTEMS

Cardiovascular [] Ankle swelling [] Leg Pain [] Palpitations [] Cold Feet/Hands [] Leg Swelling [] Vascular Disease

Gastrointestinal [] Abdominal pain [] Decreased appetite [] Heartburn [] Blood in stool [] Vomiting [] Constipation [] Diarrhea [] Ulcers

Integumentary [] Athlete's foot [] Ingrown toenail [] Nail Fungus [] Callus/Corn [] Ulcers [] Cracked Heels [] Warts [] Nail Changes

Musculoskeletal [] Ankle pain [] Bottom of Foot pain [] Heel Pain [] Arch Pain [] Toe Pain [] Ball of Foot Pain [] Flat Feet [] Top of Foot Pain

Neurological [] Numbness [] Seizures [] Tremors [] Paralysis [] Tingling [] Burning [] Weakness

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

Patient Signature: _____ Today's Date: _____

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Patient Name: _____ Date of birth: _____

The following is a list of names the patient has given consent for us to speak with regarding general medical conditions, diagnosis, or financial matters: _____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

**I acknowledge that I was provided a summary copy of the "Notice of Privacy Practices" (which was included in my new patient paperwork) and have read (or had the opportunity to) read this notice.

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because the individual refused to sign.; communication barriers or other challenge prohibited obtaining the acknowledgement. Medical staff signature:_____

Assignment of Release

**I hereby give my permission to Podiatry Specialists of Iowa to release information requested by my insurance company acquired in the course of my examination and treatment. I also give my permission to Dr. Todd Dolphin/ Dr. Kelsey Miller/ Dr. Jeffrey Klein to administer, treat and perform such general procedures as they may deem necessary in the diagnosis and/or treatment of my foot condition.

I understand I am responsible for any co-pays, deductibles and non-covered services at the time of service or upon receiving any billing statements from the office of Podiatry Specialists of Iowa. I further understand that by providing my phone numbers, I am hereby granting you, your agents, or independent contractors, my consent to receive calls for billing or debt collections purposes.

**I understand there is a fee of $35 for all returned checks. Your insurance carrier does not cover this fee.
**I understand after 90 days, any unpaid balances will be turned over to a collection agency.
**I understand it is my responsibility to contact office with any change in insurance information or change in address and/ or phone numbers.

Printed Name: _____ Today's Date: _____

Patient Signature (or Authorized Representative) _____