Houstonian
FOOT AND ANKLE SPECIALISTS

PATIENT INFORMATION

LAST NAME _____ MI_____ FIRST NAME _____
ADDRESS _____ CITY_____
ZIP CODE _____ STATE _____ DATE OF BIRTH _____/_____/_____ AGE _____
MALE _____ FEMALE _____
SOCIAL SECURITY # _____ /_____ /_____
HOME PHONE ( ) _____ - _____ WORK PHONE ( ) _____ - _____ CELL PHONE ( ) _____ - _____
EMERGENCY CONTACT _____ PHONE ( ) _____-_____ RELATION: _____
E-MAIL ADDRESS _____
MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED SEPARATED
ADDRESS _____CITY _____ STATE _____ ZIP _____
PRIMARY/REFERRING PHYSICIAN _____
OFFICE PHONE ( ) _____ -_____
PHARMACY _____

RESPONSIBLE PARTY: (COMPLETE ONLY IF PATIENT IS A DEPENDENT)
LAST NAME _____FIRST NAME_____MIDDLE INITIAL _____
SOCIAL SECURITY # _____ / _____ / _____ DATE OF BIRTH _____/_____/_____ RELATIONSHIP TO PATIENT _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE ( ) _____ - _____ WORK PHONE ( ) _____ - _____
EMPLOYER _____
ADDRESS_____CITY_____STATE _____ ZIP _____

INSURANCE INFORMATION:
INSURANCE COMPANY NAME _____
RELATIONSHIP TO PATIENT _____
SUBSCRIBER'S LAST NAME _____FIRST NAME _____ MIDDLE INITIAL _____
SUBSCRIBER'S SOCIAL SECURITY # _____ /_____ /_____ DATE OF BIRTH _____ / _____ / _____
INSURANCE NUMBER _____ GROUP NUMBER _____
EMPLOYER _____
ADDRESS _____ CITY _____
STATE _____ ZIP _____

SECONDARY INSURANCE COMPANY NAME _____RELATIONSHIP TO PATIENT _____
SUBSCRIBER'S LAST NAME _____FIRST NAME _____ MIDDLE INITIAL _____
SUBSCRIBER'S SOCIAL SECURITY # _____ /_____ /_____ DATE OF BIRTH _____ / _____ / _____
INSURANCE NUMBER _____ GROUP NUMBER _____
EMPLOYER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING
(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):
NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:
TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____

SOCIAL HISTORY

USE OF ALCOHOL □ NEVER □ NO LONGER USE □ HISTORY OF ALCOHOL ABUSE
□ CURRENT USE TYPE:_____ □ RARE □ OCCASIONAL □ MODERATE □ DAILY
USE OF TOBACCO: □ NEVER □ QUIT – HOW LONG AGO? _____ □ SMOKE _____ PACKS FOR ___YEARS
OCCUPATION: _____
HOW MUCH ARE YOU ON YOUR FEET AT WORK? _____
DO OTHERS DEPEND ON YOUR FOR THEIR CARE? □ CHILDREN(AGE) _____ □ PET(TYPE)_____
□ ELDERLY OR DIASBLED FAMILY MEMBER □ OTHER_____
EXERCISE: □ NEVER □ RARE □ OCCASIONAL □ WEEKLY □ SEVERAL TIMES A WEEK □ DAILY
TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: □ DIABETES □ CANCER □ HEART DISEASE □ HIGH BLOOD PRESSURE
□ STROKE □ CORONARY ARTERY DISEASE □ RHEUMATOID ARTHRITIS □ OTHER_____

YOUR MEDICAL HISTORY

ALLERGIES: □ NONE KNOWN □MEDICATIONS:_____□ ANESTHESIA _____
□ FOODS_____□ TAPE □ LATEX □ SHELLFISH □ IODINE □ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

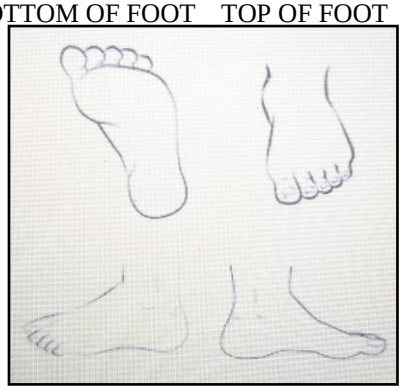
OTHER CONDITIONS: _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?_____
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

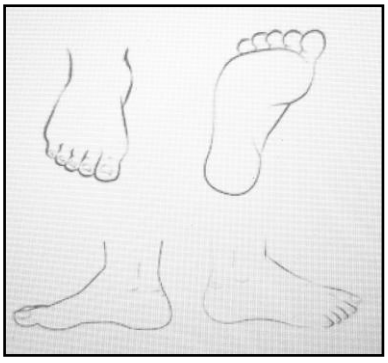
BOTTOM OF FOOT TOP OF FOOT



OUTSIDE OF FOOT INSIDE OF FOOT

RIGHT FOOT

TOP OF FOOT BOTTOM OF FOOT



INSIDE OF FOOT OUTSIDE OF FOOT

HOW LONG AGO THIS PROBLEM FIRST START? _____ DAYS/WEEKS/MONTHS/YEARS
DID YOUR PAIN/PROBLEM BEGIN: □ ALL OF A SUDDEN □ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? □ NO PAIN □ SHARP □DULL □ ACHING □ BURNING
□ RADIATING □ ITCHING □ STABBING □ OTHER _____
HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0-10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN/PROBLEM BEGAN, HAS IT: □ STAYED THE SAME □ BECAME WORSE □ IMPROVED

WHAT MAKES YOUR PAIN/PROBLEM FEEL WORSE? □ WALKING □ STANDING □ DAILY ACTIVITIES □ RESTING
□ DRESS SHOES □ HIGH HEELS □ FLAT SHOES □ ANY CLOSED TOE SHOE □ RUNNING □ OTHER_____

WHAT MAKES YOUR PAIN/PROBLEM FEEL BETTER? _____
WHAT TREATMENTS HAVE YOU HAD FOR THESE PROBLEMS? _____
HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____
WAS THIS PROBLEM CAUSED BY AN INJURY? □ NO □ YES
(DESCRIBE)_____
IF YES, WAS IT A WORK-RELATED INJURY? □ YES □ NO

ABI QUESTIONNAIRE/RISK FACTORS FOR PAD			PAD QUESTIONNAIRE/SIGNS & SYMPTOMS OF PAD	
1. AGE OVER 50?	□Y	□N	1. ABI TEST RESULT OF <0.7 FOR ONE OR BOTH LEGS?	□ Y □ N
2. DIABETES?	□Y	□N	2. LEG PAIN, AT REST OR WITH ACTIVITY, WITH OR WITHOUT OTHER OBVIOUS CAUSE?	□Y □N
3. SMOKER (CURRENT OR FORMER)	□Y	□N	3. SKIN WOUND, SCAB, INFECTION, OR ULCER ON YOUR LEG, ANKLES, OR FEET?	□Y □N
4. KIDNEY DISEASE?	□Y	□N	4. HAIR LOSS, SHINY SKIN, OR SKIN DISCOLORATION ON LEGS, ANKLES, OR FEET?	□Y □N
5. HISTORY OF CORONARY ARTERY DISEASE/CAD/HEART DISEASE?	□Y	□N	5. ONE LEG OR FOOT THAT FEELS COLDER THAN THE OTHER?	□Y □N
6. HISTORY OF CVA/STROKE?	□Y	□N	6. THICK OR YELLOW TOENAILS THAT AREN'T GROWING?	□Y □N
			7. ABSENT/DIMINISHED PEDAL PULSES?	□Y □N
IF YOU HAVE 3 OR MORE OF THESE RISK FACTORS ASK YOUR DOCTOR OR HEALTHCARE PROVIDER ABOUT AN ABI SCREENING TEST*			IF YOU HAVE ONE OR MORE OF THESE SIGNS OR SYMPTOMS, ASK YOUR DOCTOR TO REFER YOU TO NIRP** FOR A COMPREHENSIVE LOWER EXTREMITY ARTERIAL EVALUATION.	

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONISIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS

_____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____
SIGNATURE

_____
DATE

INSURANCE AUTHORIZATION AND ASSIGNMENT

I AUTHORIZE DR. E. SABETI TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO DR. E. SABETI ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. IN ADDITION, I UNDERSTAND THAT I AM RESPONSIBLE FOR INFORMING DR. E. SABETI'S OFFICE OF ANY CHANGES TO MY INSURANCE COVERAGE. I UNDERSTAND THAT BY FAILING TO INFORM DR. E. SABETI'S OFFICE OF ANY CHANGES THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED TO ME OR MY DEPENDANTS. I UNDERSTAND I AM RESPONSIBLE FOR THIS ACCOUNT. IN THE EVENT MY ACCOUNT IS TURNED OVER TO A THIRD PARTY DUE TO DEFAULT, I AM RESPONSIBLE FOR ALL COLLECTION AND ATTORNEY'S FEES AS WELL AS ALL COURT COST.

DATE _____ SIGNATURE _____

PHOTO CONSENT

I, _____ GRANT PERMISSION TO **HOUSTONIAN FOOT AND ANKLE SPECIALISTS** FOR THE USE OF THE PHOTOGRAPH(S) OR ELECTRONIC MEDIA IMAGES AS IDENTIFIED BELOW IN ANY PRESENTATION OF ANY AND ALL KIND WHATSOEVER. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING **HOUSTONIAN FOOT AND ANKLE SPECIALISTS** IN WRITING. THE REVOCATION WILL NOT AFFECT ANY ACTIONS TAKEN BEFORE THE RECEIPT OF THIS WRITTEN NOTIFICATION. IMAGES WILL BE STORED IN A SECURE LOCATION AND ONLY AUTHORIZED STAFF WILL HAVE ACCESS TO THEM. THEY WILL BE KEPT AS LONG AS THEY ARE RELEVANT AND AFTER THAT TIME DESTROYED OR ARCHIVED.

PRINTED NAME _____
SIGNATURE _____ DATE _____