Jeffrey D Fley, DPM

Please have your insurance cards available and complete these forms in their entirety.

Patient Information

Patient Name: _____ Preferred Name: _____

Gender: ( ) Male ( ) Female SSN:_____/_____/_____ DOB: ____/_____/_____

Address: _____

_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How would you like to receive appointment reminders? ( ) Phone ( ) Text ( ) Email

Where do you prefer to receive calls?: ( ) Work ( ) Home ( ) Cell

Driver's License #: _____ Email Address: _____

Primary Care Physician: _____ Date Last Seen: ____/____/_____

Race: ( )Amer Ind ( )Asian ( )Black Afr/Am ( )White Ethnicity ( )Hispanic / Latino ( )Other

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Other

Name of Spouse: _____ Spouse's Employer: _____

Year Employer: _____ Your Occupations: _____

Pharmacy: _____

Contact Information

In case of an emergency who should we contact?

Name: _____ Relationship: _____

Work #: _____ Home #: _____Cell #: _____

Address: _____

Guarantor Information

Who is responsible for this account? ( ) Same as patient

Name: _____ Relationship: _____

DOB: _____/_____/_____ SSN:_____/_____/_____ DL#: _____

Address: _____

Employer: _____

Work #: _____ Home #: _____Cell #: _____

Insurance Information

Please present your Insurance cards to the front desk

Signature: _____Date: ____/____/_____

Medication Allergies: _____

List of Medications (*Please print names, mg, and direction from your bottle or attach list*):

_____

_____

_____

Family History

Do/Did either of your parents and/or immediate family have any of the following?

( ) Blood Clots ( ) Cancer( ) Diabetes ( ) Heart Disease ( ) High Blood Pressure

( ) Rheumatoid arthritis ( ) Stroke ( ) Thyroid Disease ( ) Other _____

Patient Medical History

Do you have or have you ever been treated for any of the following conditions?

( ) Anxiety	**( ) Diabetes**	**( ) Post Traumatic Stress Disorder**
( ) Arthritis	**( ) Fibromyalgia**	**( ) Psoriasis NOS**
( ) Asthma	**( ) GERD**	**( ) Raynaud's Disease**
( ) Atrial fibrillation	**( ) Gout**	**( ) Rheumatoid Arthritis**
( ) Back Pain	**( ) HIV / AIDS**	**( ) Schizophrenia**
( ) Bipolar Disorder	**( ) Headache**	**( ) Seizure Disorder**
( ) Blood Clot	**( ) Heart Disease**	**( ) Sleep Apnea**
( ) COPD	**( ) Hepatitis**	**( ) Stroke**
( ) Cancer _____	**( ) High Blood Pressure**	**( ) Thyroid Disease**
( ) Cardiac Pacemaker	**( ) Kidney Disease**	**( ) Ulcer Disease**
( ) Cholesterol High	**( ) MS- Multiple Sclerosis**	**( ) Other** _____
( ) Chronic Liver Disease	**( ) Neuropathy**	
( ) Chronic Neck Pain	**( ) Osteoporosis**	
( ) Depression	**( ) Parkinson's Disease**	

Social History

Do you smoke? ( ) No ( ) Yes ( ) Cigarettes ( ) Cigar ( ) Pipe

Quit Date: ____/_____ How Many Years _____ Amount _____

Do you drink alcohol? ( ) No ( ) Yes if yes what type? ( ) Beer ( ) Wine ( ) Hard Liquor

Frequency: ( ) Socially ( ) Occasionally ( ) Light ( ) Heavy 3+ drinks per day

Do you use recreational drugs? ( ) No ( ) Yes, Type and Frequency _____

Surgical History

(Please list all major surgeries) _____

_____

_____

_____

Patient / Guardian Signature _____**Date: ____/____/_____**

Patient Name Printed _____ Height _____ Weight _____

Tell us how you have been feeling lately?

Have you had any problems in the following areas?

Check "none" if the answer is no.

Patient Name: _____

General Overall: ( ) None ( ) Fever ( ) Chills ( ) Headache

Eyes: ( ) None ( ) Blurred vision ( ) light sensitivity ( ) watery eyes ( ) foreign body

Ear/Nose/Mouth/Throat: ( ) None ( ) Congestion ( ) Drainage ( ) Difficulty swallowing ( ) Ringing in ears ( ) Pain ( ) Bleeding

Skin: ( ) None ( ) Rash ( ) Itchy Skin ( ) Thick, discolored nails ( ) Dry skin ( ) Wound ( ) Callus

Allergic/Immune System: ( ) None ( ) Seasonal Allergies ( ) Red painful joints

Musculoskeletal: ( ) None ( ) Back Pain ( ) Muscle Pain ( ) Joint Pain ( ) Joint Swelling

Neurologicals: ( ) None ( ) Tremors ( ) Numbness ( ) Tingling ( ) Dizziness/Fainting

Urinary: ( ) None ( ) Frequent Urination ( ) Diarrhea

Gastrointestinal : ( ) None ( ) Heartbum ( ) Acid reflux ( ) Nausea/Vomiting

Endocrine: ( ) None ( ) Excessive thirst ( ) Hot/Cold Intolerance ( ) Hot Flashes ( ) Fatigue/sluggish

Respiratory: ( ) None ( ) Wheezing ( ) Frequent cough ( ) Shortness of breath ( ) Snoring

Cardiovascular: ( ) None ( ) Chest pain ( ) Palpitations ( ) Leg/ankle swelling ( ) shortness of breath

Hematologic System: ( ) None ( ) Bloating ( ) Swelling ( ) Easy Bruising ( ) Easy Bleeding ( ) Difficulty to stop bleeding

Psychiatric: ( ) None ( ) Depression ( ) Mood Swings ( ) Anxiety ( ) Nervousness ( ) Eating disorder

Patient Initials: _____

Please Tell Us About Your Foot/Ankle Problem ?

Patients Name: _____

What is your complaint? _____
_____

Where is your pain/problem located? ( ) Toe ( ) Heel ( ) Ankle ( ) Ball of foot ( ) Arch
( ) Left ( ) Right ( ) Both
( ) Other: _____

How long have you had this complaint/condition? _____

Did the problem result from a specific injury? ( ) No ( ) Yes Please describe: _____
_____

Please rate your pain on a scale of 1-10 (10 being the most painful):
At rest 1 2 3 4 5 6 7 8 9 10 At its worst 1 2 3 4 5 6 7 8 9 10
Is the pain: ( ) Constant ( ) Occasional ( ) Sharp ( ) Dull ( ) Aching ( ) Stabbing ( ) Throbbing
( ) Radiating/Traveling
( ) Other: _____

What symptoms are you experiencing? ( ) Locking ( ) Numbness ( ) Giving Away ( ) Popping
( ) Tingling ( ) Burning ( ) Grinding ( ) Swelling ( ) Bruising
Other: _____

Does anything make your symptoms feel better? _____

Does anything meie your symptoms feel worse? _____

Have you seen another physician for this problem? ( ) No ( ) Yes Doctor's Name: _____

What treatments have you tried? ( ) Nothing ( ) Physical therapy ( )Injections ( ) Bracing ( ) Icing
( ) Compression ( ) Medications ( ) Shoe change ( ) Arch support ( ) Massage
( ) Other _____

Have you had any of the following tests/studies for this condition/complaint? ( ) Xrays ( ) Blood test
( ) MRI ( ) CT scan - If so, where were the tests performed? _____

Signature: _____**Date:** ____/____/_____

Thank you for completing these forms. We appreciate your efforts in filling them out completely. Please sign the HIPAA form and ePrescribing consent as these are a federal requirement to protect all disclosure of your health information. If you would like a copy of the "Notice of Privacy Practices' please let us know, there is a copy in our lobby for you to review.