FOOT & ANKLE SPECIALISTS
OF THE WOODLANDS
"A Step Ahead"

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last) ________________________ (First) ________________________ (MI) ________

❑ Female ❑ Male Social Security Number ____________________ Date of Birth ________________

Email ______________________________ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Home Phone ____________________________ Cell Phone ______________________________

Address ____________________________________ City ______________ Zip __________

Employment Status: ❑ Employed ❑ Student ❑ Retired ❑ Self-Employed ❑ Unemployed ❑ Disabled

Employer ______________________________ Work Phone ________________________

Emergency Contact Name ____________________ Phone ______________ Relationship __________

PRIMARY INSURANCE INFORMATION

Insurance Company Name ___________________________ Member/Policy ID # ________________

Group # ________________________ Provider Services Phone # __________________________

Policy holder: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy holder information: *(if other than self)* ________________________ Date of Birth ______________

Social Security Number __________________________ Cell Phone ________________________

Employer _________________________________ Work Phone ______________________

SECONDARY INSURANCE INFORMATION *(if applicable)*

Insurance Company Name ___________________________ Member/Policy ID # ________________

Group # ________________________ Provider Services Phone # __________________________

Policy holder: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy holder information: *(if other than self)* ________________________ Date of Birth ______________

Social Security Number __________________________ Cell Phone ________________________

Employer _________________________________ Work Phone ______________________

FINANCIALLY RESPONSIBLE PARTY

Name (Last) ________________________ (First) ________________________ (MI) ________

❑ Female ❑ Male Social Security Number ____________________ Date of Birth ________________

My signature below confirms that the information provided on this form is true and accurate to the best of my knowledge.

_____________________________________ ______________________

Patient, Parent, or Guardian's Signature ***Date***

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MEDICAL HISTORY FORM

Patient's Name: ____ Date of Birth: __________________________

Current Weight _____________________ Height ______________________ Shoe Size _______________________

Pharmacy name _____________________________________ Pharmacy number ________________________________

Primary Care Physician ____________________________________ Date last seen by PCP ________________________

How were referred you to Dr. Vaclaw?

- ❑ Physician *(Name of Referring Physician)* ____
- ❑ Internet
- ❑ Insurance
- ❑ Family/Friend
- ❑ Home Health
- ❑ Other *(please list)* ____

SOCIAL HISTORY:

Cigarette use: ❑ yes…. Packs per day? ______ ❑ no ❑ Quit…. When? _________

Cigar use: ❑ yes ❑ no ❑ Quit…. When? _________

Chewing tobacco use: ❑ yes ❑ no ❑ Quit…. When? _________

Alcohol use: ❑ never ❑ seldom ❑ daily

MEDICATIONS: *(name, dosage, how many times daily)*

❑ **NONE** ❑ **See Attached List**

____ ____

____ ____

____ ____

____ ____

____ ____

ALLERGIES: *(medications/food/substances)*

❑ **NONE**

____ ____

____ ____

____ ____

REVIEW OF SYSTEMS:

Are you **currently** experiencing any of the following signs or symptoms? If yes, please describe:

SYMPTOMS	Yes	No	Describe "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	❑	❑	____________________
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	❑	❑	____________________
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)	❑	❑	____________________
Respiratory (e.g. shortness of breath, cough, snore)	❑	❑	____________________
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	❑	❑	____________________
Genitourinary (e.g. burning, bleeding, difficulty urinating)	❑	❑	____________________
Musculoskeletal (e.g. joint, muscle, back or neck pain)	❑	❑	____________________
Skin (e.g. rash, acne, cellulitis, psoriasis)	❑	❑	____________________
Neurological (e.g. numbness, tingling, weakness)	❑	❑	____________________
Mental Health (e.g. depression, anxiety, memory loss)	❑	❑	____________________
Endocrine (e.g. weight gain/loss, excess thirst or urination)	❑	❑	____________________
Hematologic (e.g. bruising, bleeding, clotting disorder)	❑	❑	____________________
Allergic / Immunologic (e.g. rash, swelling, wheezing)	❑	❑	____________________

PAST MEDICAL and FAMILY HISTORY:

Have you or a blood related relative been diagnosed with any of the following? Please indicate which family member.

DISEASE / CONDITION	Yes	No	Family Member?
High Blood Pressure	❑	❑	____________________
Diabetes Mellitus	❑	❑	____________________
High Cholesterol	❑	❑	____________________
Angina / Heart Attack / Cardiomyopathy	❑	❑	____________________
Stroke / TIA / Seizures	❑	❑	____________________
Asthma / COPD / Emphysema	❑	❑	____________________
GERD / Ulcers / Colitis	❑	❑	____________________
Hepatitis / Liver / Gall Bladder	❑	❑	____________________
Kidney Failure / Stones	❑	❑	____________________
Urinary Tract Infections	❑	❑	____________________
Cancer	❑	❑	____________________
Arthritis / Osteoporosis	❑	❑	____________________
Bleeding / Clotting Disorder	❑	❑	____________________
Anemia / Sickle Cell Anemia	❑	❑	____________________
Thyroid / Endocrine Problem	❑	❑	____________________
HIV / AIDS	❑	❑	____________________
Tuberculosis	❑	❑	____________________
Psychiatric / Mental Disorder	❑	❑	____________________
Psoriasis / Eczema	❑	❑	____________________