Feet First Podiatry – Review of Systems & Pateient Demographics

Patient Name: _____

Review of Systems (please check 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
	☐	valve problems	☐	fainting	☐	vascular disease	☐	palpitations	☐	None
Genitourinary	☐	blood in urine	☐	hesitancy	☐	increased urgency	☐	kidney disease		
	☐	excessive urination	☐	incontinence	☐	decreased frequency	☐	kidney stones	☐	None
Gastrointestinal	☐	abdominal pain	☐	heartburn	☐	blood in stool	☐	vomiting	☐	constipation
	☐	trouble swallowing	☐	ulcers	☐	change in appetite	☐	ulcers	☐	None
Integumentary	☐	nail abnormalities	☐	keloids	☐	athlete's foot	☐	itchiness	☐	dry, scaly skin
	☐	nail fungus	☐	eczema	☐	seborrhea	☐	psoriasis	☐	None
Hematologic	☐	sickle cell disease	☐	anemia	☐	lower leg ulcers	☐	blood thinners	☐	clotting disorders
	☐	None								
Neurological	☐	neuropathy	☐	tingling	☐	weakness	☐	seizures	☐	numbness
	☐	tremors	☐	headaches	☐	paralysis	☐	None		
Musculoskeletal	☐	joint swelling	☐	back pain	☐	muscle weakness	☐	muscle pain	☐	neck pain
	☐	joint stiffness / pain	☐	sciatica	☐	joint instability	☐	arthritis	☐	None
Respiratory	☐	shortness of breath	☐	chest pain	☐	wheezing	☐	coughing	☐	snoring
	☐	emphysema	☐	COPD	☐	None				

Patient Demographics:

Race:

☐	White	☐	Black or African American	☐	Asian	☐	American Indian or Native Alaskan	☐	Native Hawaiian or Other Pacific Islander
☐	I do not know					☐	I prefer not to answer		

Ethnicity:

☐	Hispanic or Latino	☐	Non-Hispanic or Latino
☐	I do not know	☐	I prefer not to answer

Preferred Language:

☐	English	☐	Other (Specify):	☐	I prefer not to answer

Privacy Information Preferences:

May we send mail to the address on file? ____Yes ____No May we call your cell phone? ____Yes ____ No

Can we call the phone number on file? ____Yes ____No Can we leave a voicemail on machine? ____Yes ____No

Will you allow us to send internet based email delivery of reminders and newsletters? ____Yes ____No

If yes, please provide your email address: _____

Who can we leave messages with: _____ Relationship: _____

In case of emergency, who should we contact? Name:_____ Phone #:_____

Please Read and Sign: **The information on my intake form(s) 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. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medical History): I authorize the doctor's Office to retrieve my medical history and to confer with my other physician's regarding my treatment and care whenever necessary.**

Signature: X_____ **Date:** _____