Marjorie C. Ravitz, DPM PC **Today's Date:**

Name: _____ **DOB:** _____ **Chart Number:** _____

Sex: ☐M ☐F **Marital Status:** ☐Single ☐Married ☐Widowed ☐Divorced **SS#** _____

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ **Are you the insured? ☐Yes ☐No**

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐Child ☐Self ☐Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ____/____/____

Address: _____

Policy ID _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ **Are you the insured? ☐Yes ☐No**

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐Child ☐Self ☐Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ____/____/____

Address: _____

Policy ID _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone Book ☐ Family member ☐ Friend

☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1 - 10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other: _____

PLEASE READ AND SIGN

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

Patient Signature: _____ Date: _____

History and Physical

Name: _____ **DOB:** _____ **Chart Number:** _____

Medical History:

☐ Alcoholism	☐ Blood disorders	☐ Circulation problems	☐ Musculoskeletal	☐ Breathing issues
☐ Liver	☐ Sleep apnea	☐ Gout	☐ Allergies	☐ Heart Disease	☐ Asthma
☐ Heart murmur	☐ Stomach/bowel	☐ Depression	☐ Anxiety disorder	☐ Mental illness	☐ Kidney disease
☐ Blood clot	☐ High Cholesterol		☐ High blood pressure	☐ Cancer	☐ Hepatitis
Neuropathy *(specify)*_____		☐ Thyroid disease *(specify)*_____		☐ Diabetes (type 1, type 2)	
☐ Arthritis *(specify)*_____		☐ Other *(specify)*_____		☐ HIV	☐ CVA
Are you pregnant? ☐ Yes ☐ No		**Are you nursing?** ☐ Yes ☐ No		☐ Skin disorders	☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where?_____) ☐ No **Do you have an artificial heart valve?** ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No **If yes how many packs per day?** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 **For how long?** _____

Do you drink alcohol? ☐ Yes, everyday (5-7days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem

What is your occupation? _____ **Does it involve mostly** ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

_____

Family History Is there any family history (*blood relative*) of: (*Please indicate family member*)

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		_____

Review of Systems (*Please check the box if you currently have any of these symptoms or check "NONE"*)

Cardiovascular	☐ leg pain when walking ☐ fainting	☐ fever ☐ palpitations	☐ chest pain/pressure ☐ vascular disease	☐ leg swelling ☐ valve problems	☐ cold hands/feet ☐ NONE
Genitourinary	☐ blood in urine ☐ decreased frequency	☐ hesitancy ☐ excessive urination	☐ incontinence ☐ kidney disease	☐ increased urgency ☐ kidney stones	☐ NONE
Gastrointestinal	☐ abdominal pain ☐ diarrhea	☐ heartburn ☐ blood in stool ☐ vomiting ☐ trouble swallowing ☐ decrease appetite		☐ ulcers ☐ increase appetite	☐ constipation ☐ NONE
Integumentary	☐ athletes foot	☐ nail abnormalities ☐ keloids	☐ itchiness	☐ dry, scaly skin	☐ NONE
Hematologic	☐ lower leg ulcers	☐ sickle cell disease ☐ anemia	☐ blood thinners	☐ clotting disorders	☐ NONE
Neurological	☐ tingling ☐ tremors	☐ weakness ☐ paralysis	☐ seizures	☐ numbness	☐ headaches ☐ NONE
Musculoskeletal	☐ back pain ☐ sciatica	☐ joint swelling ☐ joint stiffness	☐ muscle weakness ☐ joint pain ☐ joint instability	☐ muscle pain ☐ arthritis	☐ neck pain ☐ NONE
Respiratory	☐ chest pain ☐ shortness of breath	☐ wheezing ☐ emphysema	☐ COPD	☐ coughing	☐ snoring ☐ NONE

PLEASE READ AND SIGN

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

Patient Signature:_____ Date:_____

Practice: Marjorie C. Ravitz, DPM,PC **Today's Date:**

Name: _____ **Chart #** _____ **Date of birth:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or Pacific Islander ☐ Declined to specify

Preferred Language: _____ ☐ Declined to specify

Pharmacy Name : _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who may we leave message with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Shoe Size _____

Current Medications

☐ **No known Medications** ☐ **I take the following medications:**

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Name: _____ **Dose** _____

Use the back of this form if more room is needed

Allergies

☐ **No Known Allergies** ☐ **No Known Drug Allergies**

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Name: _____ **Reaction:** _____

Did you get a pneumococcal vaccination? ☐ Yes ☐ No **Did you get Flu vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Advanced Directives: ☐ Living Will ☐ DNR ☐ Durable Power of Attorney ☐ Surrogate Appointed ☐ None

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. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ **Date:** _____