VILLAGE FOOT CARE
JAMES B. ROUSH, D.P.M.
Doctor of Podiatric Medicine

186 Village Square • Painted Post, NY 14870
(607) 936-9985

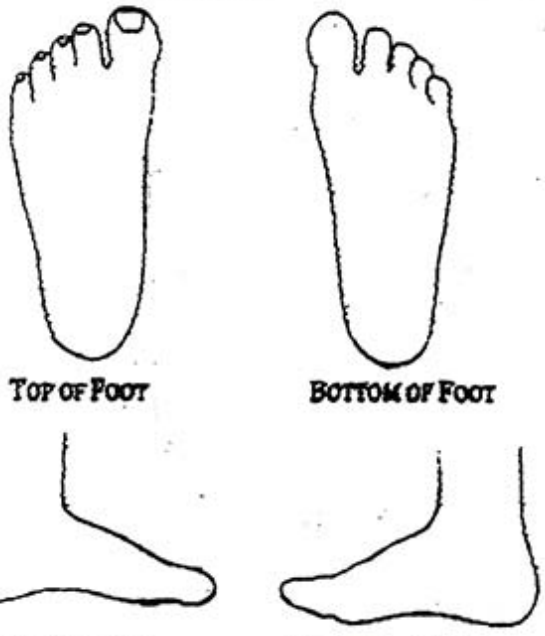
PATIENT NAME: _____
DATE OF BIRTH: ___/___/___
DATE OF APPT: ___/___/___

CURRENT PROBLEM

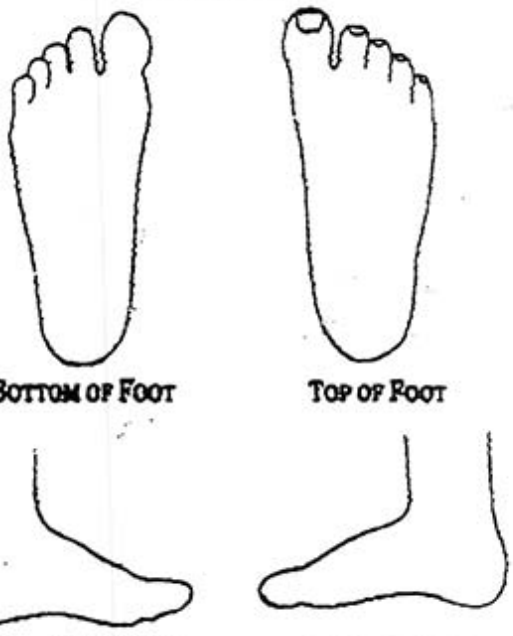
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



RIGHT FOOT



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR 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 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

MADE OUT BY: _____

Relationship To Patient: _____

Village Foot Care
Dr. Roush
Patient Registration

This paperwork was made out by _____, (relationship to patient) _____, and is accurate and up to date.

Welcome to our Office

Email _____

Patient Name _____ Date ____/____/____
First Middle Last

What name do you prefer to be called? (i.e. Bob, Trish) _____

_____PO Box_____ Apt # _____
Street Address

_____
City State Zipcode

Home Phone ( )_____ Work Phone ( )_____ Ext _____

SS # ____-____-_____ [_] Male [_] Female

Marital Status: S M D W Date of Birth ____/____/_____

Employer's Name _____

_____
Street Address City State Zipcode

Responsible Party

_____ Relationship: [_]Parent [_]Spouse [_]Self [_]Other
Name

_____
Address (if different than above)

SS# _____-_____-_____ Date of Birth: _____/_____/_____

Person to contact in case of emergency: [_] Responsible Party

Name: _____ Relationship: [_]Parent [_]Spouse [_]Friend [_]Other
Phone: ( ) _____ Address: _____

Insurance Carrier: _____ (MUST have card(s) with you)

Pharmacy: _____ **Location:**_____

How did you hear about our office? [_] Another doctor [_] Personal Recommendation
[_] Telephone book [_] Other _____

Medical Information

Family Physician _____ Phone ( ) _____
Date Last Seen _____
Are you under care of any other physician(s)/health care provider(s)?_ _ _ _ _ _ _ [_]Yes [_] No
If yes, please list doctor's/health care provider's name(s), date last seen, and reason(s) you see them.

_____Date last seen_____Reason(s)?_____

_____Date last seen_____ Reason(s)?_____

May we contact your physician(s)/health care provider(s) if any questions should arise?

[_]Yes [_]No

Have you ever been to a podiatrist before? _ [_]Yes [_]No
If yes, podiatrist's name:_____
Reason(s):_____

Describe the foot problem(s) that brought you to Dr. Roush's office today:_____
_____

How long have you had this/these problem(s)? [_]Days ___ [_] Weeks ___ [_] Months ___ [_] Years ___

Any history of broken bones in your feet, ankles, legs, or thighs/hips? _ _ _ _ _ _ _[_] Yes [_] No
If yes, please explain: _____

Any past surgery on your feet or ankles? _ [_] Yes [_] No
If yes, please explain: _____

Any cramps, burning or numbness/tingling in your feet, legs, or thigh/hips when walking?
[_] Yes [_] No

If yes, please explain _____

Any cramps, burning or numbness/tingling in your feet, legs, or thighs/hips when standing or when seated or lying down? [_] Yes [_] No
If yes, please explain _____

Your Shoe Size _____ Your current weight _____ Height _____

Are you allergic or sensitive to any medications or materials? _____ [_] Yes [_] No

Medication	**Reaction**
_____ antibiotic	_____
_____ Medication	_____
_____ Tape	_____
_____ Injections, Novocaine	_____
_____ Other	_____

Have you ever had reactions to Aspirin, Ibuprofen, Advil, Motrin, or Aleve?____ [_] Yes [_] No

General Medical Illness

Have you had any serious illnesses? _____ [_] Yes [_] No
If yes, please explain _____

Have you had any major surgeries? _____ [_] Yes [_] No
If yes, please explain _____
_____

Do you have or have you ever had a skin condition called psoriasis? _____ [_] Yes [_] No

Employment History

Are you currently employed? _____ [_] Yes [_] No
If yes, check the following that apply:

Employment: [_] sit at job [_] stand at job [_] stand and walk at job
[_] regularly carry objects over 15 pounds.

If no, check the following that apply: [_] student [_] retired [_] other. If other, please explain regular activities on your feet and if you regularly carry objects over 15 pounds.

Individual Medical History

Do you have or have you had any of the following? (v if yes)

[_] Foot/leg injuries	[_] Stroke/Mini stroke	[_] Intestinal problems
[_] Foot/leg surgery	[_] Angina	[_] Stomach or digestive ulcers
[_] Weak ankles	[_] Heart trouble	[_] Cancer
[_] Knee pain	[_] Heart attack	[_] Unexplained weight loss
[_] Unequal leg length	[_] Heart valve implant(s)	[_] Prone to infections
[_] Lower back pain	[_] Liver disease	[_] Frequent infections
[_] Artificial joints	[_] Bladder problem	[_] Healing problems
[_] Foot skin problems	[_] Kidney disease	[_] Frost bite
[_] Toenail problems	[_] Parkinson's disease	[_] Hormones
[_] Bunions	[_] Raynaud's disease	[_] Hepatitis
[_] Gout	[_] Epilepsy	[_] Tuberculosis
[_] Anemia	[_] Diabetes	[_] Blood Disease
[_] Circulation problems	[_] Fainting spells	[_] Neurological problems
[_] Hardening of the arteries	[_] Rheumatic fever	[_] Asthma
[_] High blood pressure	[_] Polio	[_] Breathing problems
[_] Varicose veins	[_] Arthritis	[_] Blood clots
[_] Phlebitis	[_] Joint Implants	[_] Bursitis
[_] Rheumatoid Arthritis	[_] Factor 5 Leiden Blood Disorder	

OTHER: please explain: _____

_____

In the past have you taken antibiotics for dental procedures or do you now? __ [_] Yes [_] No

Do you have diabetes? _____ [_] Yes [_] No

If yes, please answer the next five questions regarding your diabetes:

How many years have you had diabetes? _____ _____Years

Are you insulin dependent? _____ [_] Yes [_] No

If yes, number of years you have taken insulin _____ _____

Do you check your blood sugar level at home? _____ [_] Yes [_] No

If yes, how often do you check this? _____ _____

Do you currently smoke? _____ [_] Yes [_] No

If yes, number of years you have smoked _____ How many packs per day?_____

Did you previously smoke? _____ [_] Yes [_] No

If yes, number of years you smoked _____ How many packs per day?_____

Do you chew tobacco? _____ [_] Yes [_] No

Do you drink alcohol or beer? _____ [_] Yes [_] No

If yes, approximate amount you drink per day _____ _____

Did you previously drink alcohol or beer? _____ [_] Yes [_] No

If yes, approximate amount you used to drink per day _____ _____

If you are female, is there a chance you may be pregnant? _____ [_] Yes [_] No

Family Medical History

Mother [_] Living - Any health issues _____

[_] Deceased – Cause of death _____

Father [_] Living – Any health issues _____

[_] Deceased – Cause of death _____

Brother(s) [_] Living – Any health issues _____

[_] Deceased – Cause of death _____

Sister(s) [_] Living – Any health issues _____

[_] Deceased – Cause of death _____

Is there a family (blood relative) history of..... please check all that apply.

[_] Heart disease/attack
[_] Stroke
[_] Bleeding Disorders
[_] Blood Clots
[_] Factor 5 Leiden Blood Disorder
[_] Neurological Disorders
[_] Cancer
[_] Diabetes
[_] Arthritis
[_] Bunions
[_] Hammer Toes
[_] Flat Feet
[_] Circulation Problems in Legs/Feet
[_] Skin Cancer

Patient Authorization

I authorize payment to Dr Roush, DPM, of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges and collection costs, not paid by insurance, and for all services rendered on my behalf or on the behalf of my dependant. I authorize Dr Roush to release the information required to secure the payment of benefits for services provided and this information may include information from my medical records. I authorize the release of all medical records to my other physicians/healthcare providers. I authorize the use of this signature on all insurance submissions. I understand that payment of any non-covered services, co-pays, coinsurance and/or any deductibles are due at time of service.

I hereby give Dr Roush permission to examine and treat me.

Signature of Responsible Party: _____ Date _____

If you have Medicare, please read and sign the following:

I request that payment of authorized Medicare benefits be made on my behalf to Dr Roush, for any services furnished to me by this provider. I authorize the release of my medical and other information about me to the Health Care Financing Administration and its' agents, so that Dr Roush can determine these benefit(s) or the benefits payable for related services.

If you have a Medigap Policy, please read and sign the following:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Dr Roush, for any services furnished to me by Dr Roush.
I authorize any holder of Medicare information about me to release to my insurance carrier(s) any information needed to determine these benefits payable for related services.

Signature of Responsible Party:_____ Date _____

MEDICATION LIST

Patient's Name _____

Date of Birth _____

Date of Appointment/ Visit _____

Medication	Dosage	How Many Times Daily/Weekly	Why do you take?