THE FOOT AND ANKLE CENTER
KIRKLAND & ISSAQUAH

PATIENT HEALTH HISTORY

(*Please Print*)
Patient Name:_____ Date of Birth: _____ Age: _____
How would you like to be addressed? _____ Sex: ☐ Male ☐ Female
☐ Minor (Accompanied by _____) ☐ Single ☐ Married ☐ Widowed
Addess:_____ Apt #:_____
City:_____ State: _____ Zip:_____
Phone: (Home) _____ (Other) _____
Email Address: _____
Employer:_____ How long? _____
Occupation: _____ Student: ☐ Full-time ☐ Part-time

Person Responsible for the Account (*if different from above*)
Name:_____ Date of Birth _____ Relationship _____
Addess:_____ Apt #:_____
City:_____ State: _____ Zip:_____

INSURANCE INFORMATION – Skip over if you handed in your insurance card

Primary Insurance Company:_____ ID #:_____
Secondary Insurance Company:_____ ID #:_____
Primary Card Holder: ☐ Self ☐ Other: Relationship:_____
Primary Card Holder's Name: _____ Their DOB: _____

FOOT AND ANKLE CARE

What Problem brings you in today? _____
How long have you had these problems? _____
Have you ever broken a bone in your foot or ankle? ☐ Yes (Where and year _____) ☐ No
Please indicate current or past foot and ankle problems:
☐Ingrown Toenail ☐Athlete's Foot ☐Corns & Calluses ☐Cramps or Numbness ☐Flat Feet
☐Heel Pain ☐Foot or Leg Cramps ☐Swelling ☐Tired Feet ☐Fungus ☐Ankle Pain ☐Warts

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ **No Medications**

Allergies

-Medications:

_____
_____
_____
_____
_____
_____

-Other:

_____
_____
_____

Preferred Pharmacy

_____

#Primary Care Physician:

_____

Last seen: _____

#Former Podiatrist:

_____

Last Seen: _____

Height:_____

Weight:_____

Shoe Size:_____

Surgeries (Type and Year)

_____
_____
_____
_____
_____
_____

Hospitalizations (Diagnosis and year)

_____
_____
_____
_____
_____
_____

Do you Smoke? ☐ Yes ☐ No

Amount per day: _____

How long: _____

Do you drink Alcohol? ☐ Yes ☐ No

Amount per day: _____

Preferred drink: _____

Have you have/ever had any of the following?

Y	N		Family Member
☐	☐	Diabetes (Type___)	_____
☐	☐	Neuropathy	_____
☐	☐	Rash	_____
☐	☐	Back Problems	_____
☐	☐	Low Blood Pressure	_____
☐	☐	High Blood Pressure	_____
☐	☐	Low Blood Count	_____
☐	☐	Arthritis	_____
☐	☐	Liver Problem	_____
☐	☐	Kidney Problem	_____
☐	☐	Tuberculosis	_____
☐	☐	Varicose veins	_____
☐	☐	Blood Disease	_____
☐	☐	Gout	_____
☐	☐	MRSA Infection	_____
☐	☐	Headache	_____
☐	☐	Easy Bleeding	_____
☐	☐	Hepatitis (Type___)	_____
☐	☐	HIV/AIDS	_____
☐	☐	Shortness of Breath	_____
☐	☐	Stroke/TIA	_____
☐	☐	Thyroid Problems	_____
☐	☐	Heart Trouble	_____
☐	☐	Visual Problems	_____
☐	☐	Cancer	_____

Type_____

•Any other medical conditions the doctor should be aware of?

I hereby authorize the doctor and/or her assistants to initiate the diagnosis and treatment of my condition with examination, X-rays, photographs and/or injections, as necessary. I hereby authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance due. I understand it is my responsibility to obtain any pre0authorization and/or referral needed for my care by a specialist. I authorize the doctor or insurance company to release my information required for my claims. I authorize the doctor to release specific information concerning my illness and/or treatment to any healthcare provider involved with my treatment and care.

Patient Signature: _____ Date:_____

Account Holder's Signature (if minor) _____ Date:_____