CORNERSTONE FOOT CARE

COMPREHENSIVE FOOT & ANKLE CARE

Kimberly Ciccero, DPM

DATE: ____/_____/_____

HOW DID YOU HEAR ABOUT CONERSTONE FOOT CARE? _____
(NAME OF DOCTOR, FRIEND, INTERNET, EMAIL, FACEBOOK?)

PATIENT NAME: _____ _____ ____ DATE OF BIRTH: ____/____/____
Last First MI

Home Address: _____SSN_____

CITY/STATE: _____ ZIP: _____

CELL PHONE #: (_____) _____-_____ MAY WE LEAVE A MESSAGE/TEXT? YES NO

ALT. PHONE #: (_____) _____-_____ MAY WE LEAVE A MESSAGE? YES NO

E-MAIL: _____AGE: ____ SEX: M F

PRIMARY LANGUAGE: _____ ETHNICITY_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? ___YES___NO
IF YES, NAME: _____RELATIONSHIP: _____
PHONE #: (_____) _____-_____

EMERGENCY CONTACT: _____RELATIONSHIP: _____
PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____ PHONE #: (_____) _____-_____

PHARMACY: _____ZIP_____ PHONE #: (_____) _____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION? ___YES NAME(S) _____ ___NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____ ADDRESS: _____ CITY/STATE: _____
ZIP: _____ PHONE #: (_____) _____-_____

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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME_____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____
PHONE #: (_____) _____-_____
INSURED NAME: _____ DATE OF BIRTH _____
RELATIONSHIP TO PATIENT _____ SSN: _____
EMPLOYER _____ CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME_____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____
PHONE #: (_____) _____-_____
INSURED NAME: _____ DATE OF BIRTH _____
RELATIONSHIP TO PATIENT _____ SSN: _____
EMPLOYER _____ CONTRACT # _____ GROUP # _____

SOCIAL HISTORY

MARITAL STATUS: ___ SINGLE___ MARRIED___ PARTNERED___ SEPARATED___ DIVORCED ____WIDOWED

USE OF ALCOHOL: ___NEVER___ NO LONGER USE___HISTORY OF ALCOHOL ABUSE___ ____Yes-NUMBER OF DRINKS PER WEEK - _____

USE OF TOBACCO: ___ NEVER ___QUIT– HOW LONG AGO? ____ SMOKE _____PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ___ NEVER ___QUIT – HOW LONG AGO? _____Yes TYPE _____

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ___10%___ 25%___ 50%___ 75%___ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? YES/NO CHILDREN–AGE_____
ELDERLY OR DISABLED FAMILY MEMBER ____OTHER

EXERCISE: ___NEVER ___RARE ___OCCASIONAL ___WEEKLY ___SEVERAL TIMES A WEEK ___DAILY
TYPES OF EXERCISE: _____

HEIGHT _____ Feet _____ Inches WEIGHT _____lbs. SHOE SIZE_____

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FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: FAMILY MEMBER (EXAMPLE: MOTHER, FATHER, SISTER)?

___ DIABETES
___ CANCER
___ HEART DISEASE
___ HIGH BLOOD PREASSURE
___ STROKE
___ RHEUMATOID ARTHRITS
___OTHER_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE REASON?

13333 Lorain Ave., Cleveland, OH 44111
O. **216.941.3338** • F. **216.941.7505**

27900 Euclid Ave., Euclid, OH 44132
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YOUR MEDICAL HISTORY

ALLERGIES: ___NONE KNOWN ____YES (IF YES, PLEASE LIST OR CHECK BELOW)

MEDICATIONS_____
ANESTHESIA _____
FOODS_____
___TAPE ___LATEX___SHELLFISH___ IODINE___ OTHER_____

Medical Problems: Which of the following conditions are you currently being treated or have been treated for in the past (please check)

□Heart Disease /Murmur / Angina □Shortness of Breath □Eye Disorder / Glaucoma □Diabetes
□High cholesterol □Asthma □Seizures □Kidney / Bladder problems □High blood pressure
□Lung problems / cough/ COPD □Stroke □Liver problems / Hepatitis □Low blood pressure □Sinus problems
□Headaches / Migraines □Arthritis (rheumatoid or osteoarthritis) □Heartburn (reflux) □Seasonal allergies
□Neurological problems □Cancer □Anemia or blood problems □Tonsillitis □Depression / Anxiety
□Ulcers/colitis □ Hepatitis ____□Swollen ankles □Ear problems □Psychiatric care □Thyroid problems
□Infectious Disease (HIV, AID's)

Others/any additional information regarding your medical conditions
_____
_____
_____

Review of Systems: circle or write in any symptoms that apply to you currently

Constitutional: (nausea, recent illness, fever, chills, night sweats, anorexia, fatigue, insomnia, weight gain/loss) _____

Eyes (visual changes, cataract, glaucoma, discharge, injuries, glasses or contacts) _____

Head, Ears, Nose, Throat (head injuries, headache, dizziness, difficulty with hearing, pain, discharge, ear infections, ventilation tubes, sinus congestion, sore throat, discharge: watery or purulent, difficulty in breathing through nose, bloody nose, sore throat or tongue, difficulty in swallowing, dental defects, swollen glands, masses) _____

Lungs (shortness of breath, ability to keep up with peers, cough, wheezing) _____

Heart (cyanosis, arrhythmia, edema, heart murmurs or "heart trouble," pain over heart), _____

Gastrointestinal (nausea, vomiting, abnormal bowel movements, abdominal pain, jaundice, reflux) _____

Genitourinary (dysuria, hematuria, urethral or vaginal discharge, sores, pain, venereal disease, pregnant, abortions) _____

Musculoskeletal (back pain, stiffness, swelling, muscle weakness, deformities, difficulty in moving extremities or in walking, joint pains and swelling, muscle pains or cramps) _____

Skin (skin cancer, rashes, calluses, nail changes, psoriasis, cellulitis, skin color change, abnormal moles, easy bruising or bleeding) _____

Neurologic (headaches, fainting, dizziness, seizures, numbness, tremors) _____

Psychiatric (nervousness/anxiety, drug use or abuse, psychosis, suicidality) _____

Endocrine: Hypo/Hyper-thyroid, hyperglycemic/diabetes _____

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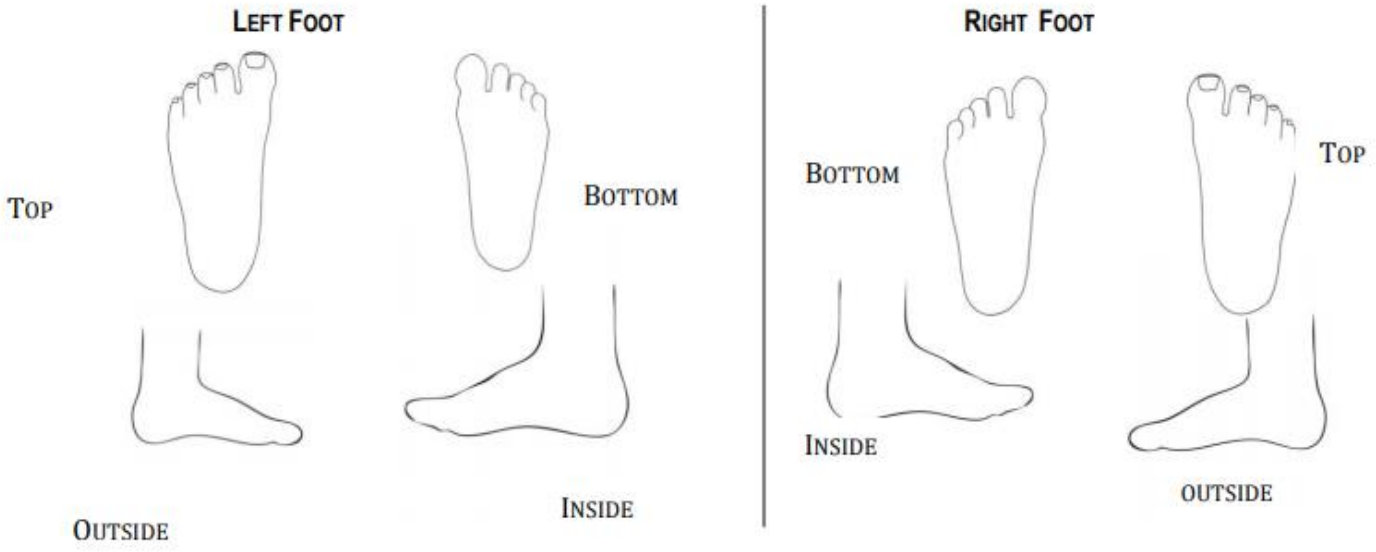
CURRENT PROBLEM (CHIEF COMPLAINT)
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

_____

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



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 DESCRIBE YOUR PAIN? (PLEASE CIRCLE)
NO PAIN MILD PAIN MODERATE PAIN SEVERE PAIN

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ___STAYED THE SAME___BECOME WORSE___ IMPROVED

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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 BELOW) ___NO
_____
_____
_____ _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____DATE _____
SIGN NAME OF PATIENT, PARENT OR GUARDIAN

REVIEWED BY OUTSIDE INSIDE OUTSIDE TOP BOTTOM OF FOOT BOTTOM TOP BOTTOM INSIDE 4

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