CONFIDENTIAL SEGEL PODIATRY Patient Name:

CONTACT INFORMATION

First: _____ Last: _____MI:____ Birth Date: ____ /_____/____

Mailing Address P.O BOX _____ Street: _____

City/Town:_____ State :_____ Zip Code: _____

Alternative / Off-Island Address: _____

City/Town:_____ State :_____ Zip Code: _____

Phone: _____ Cell/Business: _____ E-mail : _____

Occupation: _____ Hours/Day on Feet : _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Spouse Name if married: _____

Primary Insurance: Medicare, BC/BS, Harvard Pilgrim, Allways Partners Policy #: _____

Secondary Insurance: _____ Policy: _____

Primary Care Physician: _____ Last Seen : _____Why: _____

Seen a Podiatrist before: YES NO, where: _____ Why: _____

Reason for this visit _____How long you had this issue _____

Is the Problem: New Established Worsening Had it before Many Years

Pain level: /10 When: AM PM Constant Intermittent

What makes it better: _____ Has Anyone else seen you for this problem:_____

Other foot issues: _____ Referred by:_____

List other Medical Problems: _____

Payments: Patient are responsible for all fees including missed visits and returned checks. Interest and late feeds may apply on past due balances. Payment is expected at the time of service. Payment exceptions must be arranged before treatment. I understand that referrals if needed are my responsibility.

I authorize Dr. Jay Segel to provide services and medicines, submit my insurance form, consider my signature "on file" for payment, pictures and to release any & all records needed for insurance processing and communications with other caregivers, including imaging.
I understand the HIPPA, office privacy policy, and have read and understand the above and agree to be personally responsible for all charges and fees

Signature of patient or responsible: _____ Date: _____/_____/_____

CONFIDENTIAL SEGEL PODIATRY Patient Name:

PATIENT INTAKE FORM:

LIST YOUR ALLERGIES:_____

Medical Family Hx: _____

Hospitalized: Yes No Where: _____ Why: _____

Recent Blood Pressure: _____ Weight: _____ Height: _____ Shoe Size: _____

Do you take: Blood Thinners, Heart Meds, Anti-depressants, Antibiotics, Blood Pressure Medicine

Medication List Prescribed and Dosages: _____

_____

List of Operations: _____

CONSTITUTIONAL

Chills	Yes	No	Fatigue	Yes	No	Fever	Yes	No
Weakness	Yes	No	Weight gain	Yes	No	Weight loss	Yes	No
Dimentia l	Yes	No	Disturbed Sleep	Yes	No	Chronic Pain	Yes	No

HEAD

Dizziness	Yes	No	Fainting	Yes	No	Headaches	Yes	No
Pain	Yes	No	Sweats	Yes	No	Migraine	Yes	No
Injury	Yes	No						

RESPIRATORY

Asthma	Yes	No	Cough	Yes	No	Wheezing	Yes	No
Bronchitis	Yes	No	Pleurisy	Yes	No	Short of Breath	Yes	No
COPD	Yes	No	TB	Yes	No	Pneumonia	Yes	No

CARDIO/CIRCULATORY

Chest Pain	Yes	No	Varicose Veins	Yes	No	Extremity(s) Cool	Yes	No
Hair Loss on Legs	Yes	No	Heart Murmur	Yes	No	High Blood Pressure	Yes	No
Rheumatic Fever	Yes	No	Cramps in legs/feet	Yes	No	Hx of MI	Yes	No
Leg or Foot Ulcers	Yes	No	Palpations	Yes	No	Replacement heart valve	Yes	No
Vascular grafts	Yes	No	Heart Attack	Yes	No	Raynaud Syndrome	Yes	No
Poor Circulation	Yes	No	Cold Feet	Yes	No	Hx of Blood Clots	Yes	No

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GI/GU

Constipation	Yes No	Diarrhea	Yes No	Jaundice	Yes No
Liver Disease	Yes No	Rectal Bleeding	Yes No	Antacid Use	Yes No
Excessive Thirst	Yes No	Hepatitis	Yes No	Nausea	Yes No
Swallowing Problem	Yes No	Gall Bladder Disease	Yes No	Heart Burn	Yes No
Hemorrhoids	Yes No	Laxatives	Yes No	Abdominal Pain	Yes No

MUSCULOSKELETAL

Joint Pain	Yes No	Gout	Yes No	Amputation	Yes No
Lower Back Pain	Yes No	Knee Pain	Yes No	Back Problems	Yes No
Joint Stiffness	Yes No	Muscle Cramps	Yes No	Paralysis	Yes No
Restricted Motion	Yes No	Weakness	Yes No	Ankle Sprain	Yes No
Arch Pain	Yes No	Sores	Yes No	Broken Foot Bone	Yes No
Bunions	Yes No	Calluses	Yes No	Childhood Foot Prob.	Yes No
Corns	Yes No	Flat Feet	Yes No	Gait (Walking) Prob.	Yes No
Hammer/Mallet Toes	Yes No	Heel Pain	Yes No	High Arch Feet	Yes No
In-Toeing	Yes No	Joint Implants	Yes No	Muscle Stiffness	Yes No
Neuroma	Yes No	Orthotic Use	Yes No	Shoe Insert Use	Yes No
Toe Walking	Yes No	Tired Feet	Yes No	Hernia	Yes No
Plantar Fasciitis	Yes No	Broken Ankle	Yes No →	Specify: _____	
Surgery	Yes No →	Specify: _____			
Plate/Screws	Yes No →	Specify: _____			
Arthritis	Yes No				

PSYCHIATRIC

Depression	Yes No	Disorientation	Yes No	Memory Loss	Yes No
Anxiety	Yes No	Schizophrenia	Yes No	Bi-Polar	Yes No
SAADS	Yes No	Family Hx	Yes No		

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SKIN

Eczema	Yes No	Itching	Yes No	Warts	Yes No
Dryness	Yes No	Hives	Yes No	Lumps	Yes No
Athlete's Foot	Yes No	Fungal Nails	Yes No	Ingrown nails	Yes No
Keloid Scar	Yes No	Mole Changes	Yes No	Rash	Yes No
Dermatitis	Yes No	Psoriasis	Yes No	Corn/Callus	Yes No
Infection	Yes No	Frostbite	Yes No		

NEUROLOGICAL

Burning	Yes No	Fainting	Yes No	Numbness	Yes No
Speech Disorder	Yes No	Strokes	Yes No	Tingling	Yes No
Tremors	Yes No	Unsteady gait	Yes No	Black Outs	Yes No
Charcot Neuroarthropathy	Yes No	Neuromas	Yes No	Epilepsy	Yes No
Parkinson Dx	Yes No	Neuropathy	Yes No	Tick Bite	Yes No

ENDOCRINE

Weight gain	Yes No	Weight Loss	Yes No	Fatigue	Yes No
Goiter	Yes No	Sweats	Yes No	Thirst	Yes No
Thyroid	Yes No	MS	Yes No	BPH	Yes No
Renal Stone	Yes No	Ulcer	Yes No		

Pregnant Yes No → # Full Term Pregnancies _____ #Miscarriages:_____

Immune Problems Yes No → Specify: _____

Diabetes Yes No → Last Reading:_____ How often do you check: _____ Onset Date: _____

ALLERGIC /IMMUNOLOGIC

Hives	Yes No	Itchy Eyes	Yes No	Itchy Nose	Yes No
Runny Nose	Yes No	Sneezing	Yes No	Stuffy Nose	Yes No
Watery Eyes	Yes No	Wheezing	Yes No	Swelling	Yes No
Lyme Dz	Yes No				

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HEMATOLOGIC

Anemia	Yes No	Bleeding Easily	Yes No	Blood Clots	Yes No
Easy Bruisability	Yes No	Swollen Glands	Yes No	Transfusion Reaction	Yes No
Slow Healing Cuts	Yes No	Recent Chemo.	Yes No	HIV	Yes No
Cancer	Yes No	Specify: _____			

EYE

Blurred vision	Yes No	Cataracts	Yes No	Contacts	Yes No
Eyeglasses	Yes No	Glaucoma	Yes No	Infections	Yes No
Double Vision	Yes No	Macular Degeneration	Yes No	Blindness (legal)	Yes No
Prev. Eye Surgery	Yes No	Specify: _____			

TOBACCO USE

Cigarettes	Light	Someday	Everyday	Never	Former	Daily Usage:
Cigars	Light	Someday	Everyday	Never	Former	Daily Usage:
Pipe	Light	Someday	Everyday	Never	Former	Daily Usage:
Chewing Tobacco	Light	Someday	Everyday	Never	Former	Daily Usage:
Dipping Tobacco	Light	Someday	Everyday	Never	Former	Daily Usage:

ALCOHOL USE

Beer	Social	Occasional	Light	Heavy	No Use
Wine	Social	Occasional	Light	Heavy	No Use
Hard Liquor	Social	Occasional	Light	Heavy	No Use

Have you ever felt you should Cut down on your drinking?	Yes	No
Have people Annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or Guilty about your drinking?	Yes	No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?	Yes	No

Additional Information: