Elmhurst Foot & Ankle Center
183 W 1st St,
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office@footankleil.com

FOOT & ANKLE CENTER
ELMHURST
(630)-530-3338

Schaumburg Foot & Ankle Center
1375 E Schaumburg Road, Ste 210
Schaumburg, IL 60193

www.footankleil.com

Patient Information Form

(Please Print)

Date: ___/____/____

Patient Name: _____ _____ ___ Date of Birth: ___/___/___ Age: __ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

May we leave a message?

Home Phone #: (____) ____-_____ Yes No

Work Phone #: (____) ____-_____ Yes No

Cell Phone #: (____) ____-_____ Yes No

E-mail: _____ Yes No

Primary Language: _____

Race:_____ 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: _____ Location: _____ 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 #: (____) ____-_____

Who Referred You To Us?_____

Insurance Information

Primary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) ____-_____

Patient Name: _____
Date of Birth: ____/____/_____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____

Secondary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) ____-_____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Name Dose How often do you take?

_____

_____

_____

_____

_____

_____

Please list all prior surgeries:

Type of Surgery Date Type of Surgery Date

_____

_____

_____

Please list all prior hospitalizations (other than for surgery):

Reason For Hospitalization Date Reason For Hospitalization Date

_____

_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ___ packs/day for ___ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind? _____
☐ Elderly or disabled family member ☐ Other _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily

Patient Name: _____
Date of Birth: ____/____/_____

Types of exercise: _____

Family History

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease
☐ Rheumatoid Arthritis ☐ Other _____

Your Medical History

Allergies: ☐ Medications _____ ☐ Anesthesia _____
☐ Foods _____ ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other _____
☐ None Known/No Known Drug Allergies

Have you ever had any of the following?

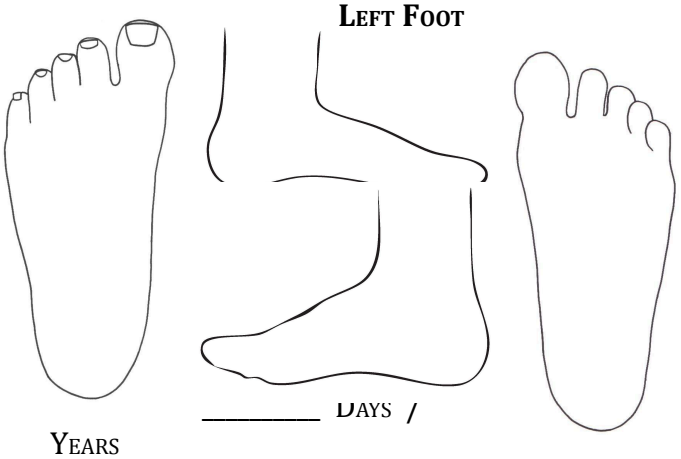
Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Other Conditions:								

Current Problem

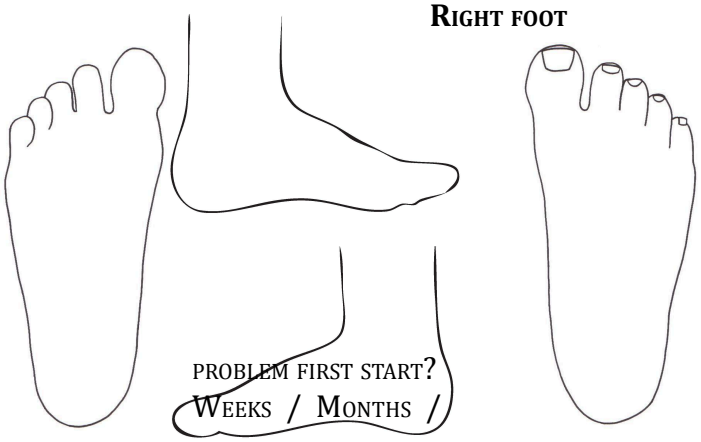
What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot



Right foot



_____ Days / Weeks / Months / Years

problem first start?

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

Patient Name: _____
Date of Birth: ____/____/_____

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

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.

_____
Print name of patient, parent or guardian

_____
If other than patient, relationship to patient

_____
Signature

_____
Date