LEMBERGER PODIATRY
PATIENT INFORMATION FORM

PATIENT NAME: FIRST: _____ LAST:_____

DATE OF BIRTH: ___/___/_____ AGE: _____ SEX: M F

HOME ADDRESS: _____

CITY/ _____ STATE_____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (_____) _____-_____ YES NO

ALTERNATE PHONE #: (_____) _____-_____ YES NO

E-MAIL: _____ YES NO

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

PRIMARY CARE DOCTOR: _____

WHO REFERRED YOU TO US? _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

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 # _____

MEDICAL INFORMATION:

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	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER MEDICAL PROBLEMS_____

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

_____

_____

_____

PLEASE LIST ALL PRIOR SURGERIES:

_____ _____

_____ _____

_____ _ _____

ALLERGIES: ☐ NONE ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE
☐ PENICILLIN ☐ ASPIRIN

☐ OTHERS _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ HISTORY OF ALCOHOL ABUSE

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER

_____

CURRENT PROBLEM

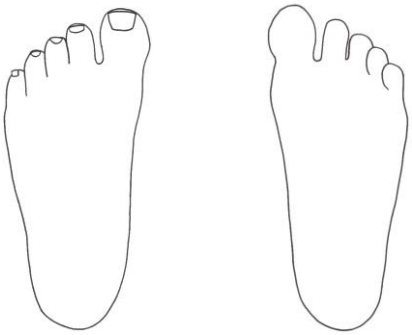
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HOW LONG HAVE YOU HAD THE CURRENT CONDITION☐UNKNOWN, ___DAYS ___WEEKS ___MONTHS ___YEARS

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

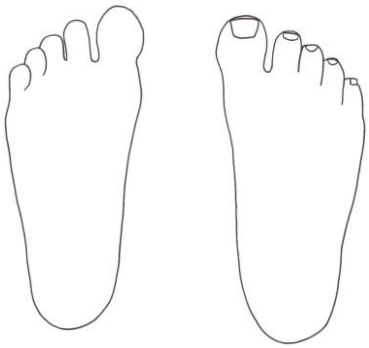
LEFT FOOT

TOP BOTTOM



RIGHT FOOT

BOTTOM TOP



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 TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐YES (DESCRIBE) _____ ☐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.
*ASSINGMENT OF BENEFITS/FINANCIAL POLICY: I HERBY ASIGN TRANSFER OF PAYMENT BENEFITS MADE TO ME ON THE BEHALF OF DR. STEVEN LEMBERGER FOR SERVICES FURNISHED TO ME. I HAVE READ AND AGREE TO PAY ANY AMOUNT DUE ACCORDING TO THE FINANCIAL POLICY.
*RELEASE OF INFORMATION: I HEARBY AUTHERIZE DR. STEVEN LEMBERGER TO RELEASE INFORMATION ACQUIRED DURING THE COURSE OF MY EXAMINATION OR TREATMENT TO MY REFERING PHYSICAINS OR TO AN APPROPRIATE INSURANCE CARRIER THAT MAY BE NECESSARY FOR FURTHER MEDICAL CARE AND REIMBURSMENT OF SERVICES RENDERED.,
*RECEIPT OF PRIVACY PRACTICES: I ACKNOWLEGE THAT I WAS PROVIDED WITH A COPY OF PRIVACY PRACTICES AND THAT I HAVE READ AND UNDERSTAND THE NOTICE.
*CONSENT FOR TREATMENT: I AUTHORIZE DR. LEMBERGER TO PROVIDE ME WITH MEDICAL EVALUATION AND TREATMENT.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

DATE:_____