1150 Professional Court, Suite C
Hagerstown, MD 21740
(301) 797-8554

Reconstructive Foot & Ankle Institute, LLC

2100 Old Farm Drive, Suite D
Frederick, MD 21702
(301) 418-6014

PATIENT REGISTRATION – Please Print Clearly and Fill out Completely

PATIENT NAME Last	First	Middle	ACCOUNT #	SEX	MARITAL STATUS ❑ S ❑ M ❑ D ❑ W

RACE	ETHNICITY: HISPANIC NON HISPANIC	NATIONALITY	LANGUAGE

DATE OF BIRTH	SOCIAL SECURITY NO.	HOME PHONE	CELL PHONE

HOME ADDRESS	APT NO	CITY	STATE	ZIP

REFERRED BY	FAMILY DOCTOR	FAMILY DOCTOR PHONE NUMBER	DATE OF ILLNESS/INJURY

EMPLOYER	WORK PHONE	PERSONAL E-MAIL ADDRESS

PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR	RELATIONSHIP

PREFERRED PHARMACY	PHARMACY PHONE

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I hereby authorize Reconstructive Foot & Ankle Institute, LLC to release medical information to my insurance carrier(s) for the sole purpose of obtaining payment for my medical care. I agree that a copy of this release may be used in place of the original. I hereby authorize Reconstructive Foot & Ankle Institute, LLC to request records from my other treating physicians.

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I hereby authorize Reconstructive Foot & Ankle Institute to release medical information to my referring physician, primary care doctor, case manager, pharmacy and any other individual involved in my medical care for sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right I will provide in writing to my physician any of the individuals involved in my care to which I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this release of Medical information may be revoked at any time by providing the physician's office with a dated and signed letter.

ACCURATE HISTORY

I understand that honest and complete answers to each question stated herein are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES AND THE FINANCIAL POLICY"

The HIPPA educational pamphlet provides information about how Reconstructive Foot & Ankle Institute may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996(HIPPA). We reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail or in person. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you. By signing below, you acknowledge receipt of our HIPPA regulations.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice and Financial Policy from Reconstructive Foot & Ankle Institute, LLC.

_____
Patient Name (printed)

_____ _____
Patient or Legal Guardian Signature Date

CONTACTS

With consent Dr. Daniel Michaels, DPM, and/or his staff may discuss my protected health information, including course of treatment, scheduling and billing information, with the following individuals:

_____ _____
Name and Relationship Name and Relationship

_____ _____
Phone Number Phone Number

❑ NO DESIGNEE

Updated 8/12/2015

Date: _____

Initial Comprehensive Foot & Ankle Questionnaire

Please complete this form before your first appointment at the Reconstructive Foot & Ankle Institute, LLC. Your careful answers will help us to understand your foot and ankle problem (s) and design the best treatment plan for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g. Workmen's Compensation Claims).

Name:_____ **Age**: _____ **Height:** _____ **Weight:** _____

Shoe Size: _____ **Family Physician:** _____

How did you hear about our office? _____

Describe your foot or ankle problem: ❑ Right ❑ Left ❑ Bilateral (both) _____

Describe any treatment you have tried for your problem (including any treatment from previous doctors): _____

_____

Where is your pain? (Check all that apply)

❑ Heel/Arch Pain
❑ Ankle pain (outside, inside, front, back of ankle)
❑ Foot pain (top, bottom)
❑ Toe Problem (big toe, 2nd, 3rd, 4th, 5th)

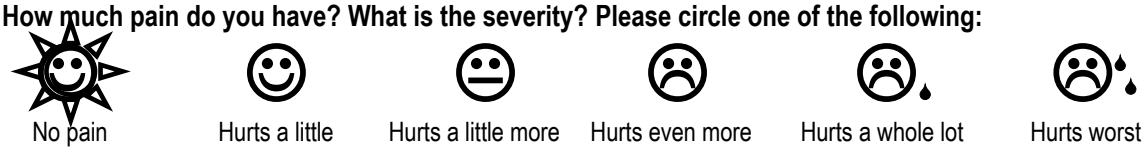
How long have you had your current problem?

_____ Days _____ Months
_____ Weeks _____ Years

Onset of problem: How did your current problem start?

□ Injury at work
□ Injury, not at work
□ Motor vehicle accident
□ Illness, non-injury
□ Treatment caused (e.g. radiation, surgery, etc)
□ Undetermined
□ If there was a precipitating event not mentioned, what was it? _____

How much pain do you have? What is the severity? Please circle one of the following:



No pain	Hurts a little	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts worst
0	1-2-3	4-5	6-7	8-9	10

Timing of problem / pain: How often do you have your pain? (check one)

□ Constantly (100% of the time)
□ Intermittently (30-60% of the time)
□ Occasionally (less than 30% of the time)
□ Nearly constantly (60-95% of the time)

In general, during the past month, when has your pain/problem been the worst? (check one)

□ Morning □ Night □ Afternoon □ Evening □ No typical pattern

Symptom quality: How would you describe your pain?
(Check all that apply and circle the dominant quality)

□ Burning □ Sharp □ Cutting □ Throbbing □ Electric □ Cramping
□ Dull/aching □ Pressure-like □ Shooting □ Pins and needles □ Walking on a pebble □ Pain on first step of day
□ Other (describe) _____

Relieving and aggravating factors:

How does the following affect your pain? (check one for each activity)

Activity	Decrease	No Change	Increase
Standing			
Sitting			
Walking			
Exercise			
Elevation			

Check all that apply:

Aggravated by:
Weather ___ Shoe ___ Touch ___

Relieved by: Heat ___ Cold ___ Rest ___
Meds ___ Ace or compressive wrap ___

Activities and your pain:

How many blocks can you walk?
□ Less than a block, or
□ How many blocks?_____

To assist walking, I use a:
□ Cane
□Walker
□Wheelchair
□No assistive device

Are you NOT able to perform any of the following activities of daily living? (Check all that apply)
□Going to work □Performing household chores
□Wearing shoes □Doing yard work or shopping
□Exercising □Participating in recreational activities

Past personal & family medical history:

For each condition, check Yes or No for you, *and* check if you have a family history (FM HX)

	YES	NO	FM HX		YES	NO	FM HX
Alcoholism				Heart Condition			
Anemia				Heart Valve Issues			
Angina/ Chest Pain				High Blood Pressure			
Asthma				High Cholesterol			
Bleeding Disorder				Infection Prone			
Blood Clots (DVT)				Kidney Condition			
Blood Thinner				Liver Condition			
Bone Fracture				Obesity			
Cancer				Osteomyelitis			
Depression				Parkinson Disease			
Diabetes				Polio			
Emphysema				Raynauds			
Epilepsy / Seizures				Rheumatic Fever			
Fainting				Rheumatoid Arthritis			
Fibromyalgia				Sickle Cell			
Foot Disorder				Thyroid Condition			
Foot Surgery				Tuberculosis			
G.I. Condition				Ulcer			
Gout				Vascular Disease			
Heart Attack /Stroke				Vascular Necrosis			

Please list any other condition(s)
_____
_____
_____

Have you ever been a smoker?
□ Yes – Current
□ Yes – In the past
□ No - Never

If you smoke, how many packs per day?
_____packs/day
For how many years did you smoke?
_____years

If you are unemployed or employed part time, is this due to your present foot condition? □ Yes □ No
If you are currently unemployed, indicate how long you have been off work: _____

If you have <u>diabetes</u> please answer the following questions:

How long have you had diabetes? _____Years _____Months
What is your usual blood sugar level by finger stick? _____
How many times a day do you check your finger stick blood sugar? _____

Have you ever had a blood-clot? _____
Do you take insulin? _____

Past surgical history: Please list any hospitalizations/surgeries with approximate dates.

Surgeries/ Injuries	Date	Surgeries/ Injuries	Date
Abdominal surgery		CABG (heart bypass)	
Amputation		Cardiac Surgery	
Angioplasty		Cancer Surgery	
Ankle surgery		Cataract Surgery	
Appendectomy		Cholecystectomy	
Artificial joint		Cosmetic Surgery	
Back surgery		**Foot Surgery**	
Biopsy		GYN Surgery	
Bowel surgery		Vascular Surgery	

List other surgeries:_____

Allergies: What allergies do you have?

	Reaction		Reaction
Aspirin		Ampicillin	
Codeine		Tylenol	
Iodine (Seafood)		Eggs	

Allergies (cont.)	Reaction		Reaction
Novocain		NSAIDS	
Penicillin or other antibiotics		Latex	
Tape		Glove Powder	
Sulfa drugs		Demerol	
Cortisone		Morphine	

List any other allergies: _____

Current medications:

Name of Medication	Dose	Frequency

Review of systems: Please circle yes or no if you have any of the following problems:

□ Constitutional

Good general health	Yes	No
Recent Weight changes	Yes	No
Night sweats, Fevers	Yes	No
Fatigue	Yes	No

□ Eyes

Wear glasses/ contacts	Yes	No
Blurred/ double vision	Yes	No
Eye disease or injury	Yes	No
Glaucoma	Yes	No

□ Cardiovascular

Chest pain	Yes	No
Palpitations	Yes	No
Heart Trouble	Yes	No
Swelling hands/feet	Yes	No

□ Musculoskeletal

Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No

□ Integumentary (Skin/Breast)

Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain or discharge	Yes	No

□ Endocrine

Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Hormone problem	Yes	No

□ Genitourinary – Male Only

Blood in Urine	Yes	No
Kidney stones	Yes	No
Kidney Failure	Yes	No
Dialysis	Yes	No

□ Psychiatric

Insomnia	Yes	No
Confusion/ Memory loss	Yes	No
Depression	Yes	No

□ Ears/Nose/Throat/Mouth

Hearing loss or ringing	Yes	No
Sinus Problems	Yes	No
Nose Bleeds	Yes	No
Sore throat/ voice change	Yes	No

□ Gastrointestinal

Nausea/ vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No

□ Respiratory

Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/ asthma	Yes	No
Coughing up blood	Yes	No

□ Neurological

Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Convulsions/ seizures	Yes	No
Numbness/ tingling	Yes	No

□ Allergic/ Immunologic

Food allergies	Yes	No
Aspirin allergies	Yes	No
Antibiotic allergies	Yes	No

□ Hematologic/ Lymphatic

Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No

□ Genitourinary – Female Only

Blood in Urine	Yes	No
Kidney stones	Yes	No
Kidney Failure	Yes	No
Dialysis	Yes	No

□ Other

_____
_____
_____