Patient Information

671 E. Riverpark Ln., Ste. 110
Boise, ID 83706
208 387-0900
Fax 208 345-5883

Park Center Foot & Ankle Clinic

Doctor of Podiatric Medicine & Certified Surgeon

Randy E. Lowe, DPM

Visit Date:	Have you been seen in our office before? ☐ No ☐ Yes — Approx. Date:

PATIENT INFORMATION

Last Name	First Name	Middle	DOB / /	Age	Sex ☐ M ☐ F
Street Address	City	State	Zip		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Other
Mailing Address	City	State	Zip		
Email Address		Social Security No.			
Home Phone ☐ Preferred ( )	Cell Phone ☐ Preferred ( )	Work Phone ☐ Preferred ( )			
Employer	Occupation	Address	City, State, Zip		

IN CASE OF EMERGENCY

Local friend/relative (not living at same address)	Relation	Cell Phone	Work Phone

PARENT/LEGAL GUARDIAN INFORMATION ***(Required only if patient is under 18 years old)***

Guarantor Name	SS#	Sex ☐ M ☐ F	DOB / /	Age
Email Address	Best Contact # ☐ Home ☐ Work ☐ Cell	Can we leave a message? ☐ Yes ☐ No		
Street Address	City, State, Zip	Relation		

CHOSE CLINIC ☐ Location ☐ Insurance Plan ☐ Web Site ☐ Other:
BECAUSE _____

REFERRED ☐ Insurance ☐ Physician ☐ Other
BY _____

INSURANCE INFORMATION

Primary Ins. Co		**Employer**
Policy #		**Group #**
Policyholder	**DOB**	**Relation** ☐ Self ☐ Spouse ☐ Dependent
Secondary Ins. Co		**Employer**
Policy #		**Group #**
Policyholder	**DOB**	**Relation** ☐ Self ☐ Spouse ☐ Dependent

ALL PATIENTS PLEASE READ & SIGN

I authorize payment of medical benefits from Medicare, Medigap, private and/or group insurance be made on my behalf to Park Center Foot & Ankle Clinic for any services or supplies furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance company any information needed to determine benefits for related services. I also take responsibility for payment of charges, regardless of payment or denial of payment from my insurance company.

_____ _____ _____

Patient or Patient Representative | Relationship (if not self) | Date

Current Concerns

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Patient Name _____ Visit Date _____

Describe Issue											
Circle Area Affected	**Foot**	**Toes**					**Other**				
	Right	Great	2nd	3rd	4th	5th	Nail	Heel	Arch	Ball	Side
	Left	Great	2nd	3rd	4th	5th	Nail	Heel	Arch	Ball	Side

	Top	Joints	Ankle	Entire					
	Top	Joints	Ankle	Entire					

Quality	☐ aching	☐ stabbing	☐ dull	☐ occasional	☐ worsening	**Severity**
	☐ burning	☐ throbbing	☐ superficial	☐ frequent	☐ improving	
	☐ gnawing	☐ sharp	☐ deep	☐ constant	☐ not changing	

Pain level ___/10
☐ no pain ☐ mild
☐ moderate ☐ severe

How long has it bothered you? _____ Days _____ Weeks _____ Months _____ Years

Timing	☐ cannot identify	☐ abrupt	☐ daytime	☐ rare ☐ occasional
	☐ acute	☐ gradual	☐ nighttime	☐ intermittent episodes lasting:
	☐ chronic	☐ morning	☐ recurrent	☐ other:

Improves With		
☐ nothing helps	☐ elevation	☐ brace
☐ sitting	☐ exercise	☐ crutches
☐ standing	☐ stretching	☐ cane
☐ lying down	☐ limited weight bearing	☐ wheelchair
☐ position change	☐ PT/OT	☐ walker
☐ heat	☐ OTC medication	☐ removal of shoes
☐ ice	☐ narcotics	
☐ rest	☐ NSAID's	
☐ Other:		

Worse with	
☐ cannot identify	☐ morning
☐ sitting	☐ daytime
☐ standing	☐ nighttime
☐ lying down	☐ cold weather
☐ walking	☐ bare foot
☐ lifting	☐ flat shoes
☐ range of motion	☐ wearing heels
☐ weight lifting	
☐ Other:	

Associate Symptoms	☐ weakness	☐ tingling	☐ redness	☐ instability	☐ drainage	☐ other
	☐ numbness	☐ swelling	☐ warmth	☐ radiation down the leg	☐ bleeding	_____

PREVIOUS FOOT SURGERIES/PROCEEDURES & YEAR ☐ None	**PRIOR IMAGING**
	☐ None ☐ x-ray ☐ MRI ☐ labs ☐ ultrasound

Prior ☐ None	comments:	☐ did not help	☐ temporarily
		☐ helped a little	☐significantly

Other Treatments ☐ None	☐ orthotics ☐ night splint ☐ physical therapy ☐ other	comments:	☐ did not help ☐ helped a little ☐ temporarily ☐ significantly

Patient History

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Primary Care Physician		Last Visit	
Preferred Pharmacy		Address/Cross Road	

Medication Allergies ☐ No Known Allergies
☐ Latex ☐ NSAIDS ☐ Adhesives ☐ Aspirin ☐Codeine ☐ Iodine/betadine
☐ Novocaine ☐ Penicillin ☐ Anesthesia ☐ Sulfa ☐ Other:

Diabetes ☐ **No** ☐ **Yes**

Diagnosed _____ (approximate year)
Type ☐ 1 ☐ 2
☐ Pre-Diabetic

Treatment (√ all that apply) ☐ Insulin ☐ Oral Medication ☐ Lifestyle
Controlled (Acceptable A/C) ☐ Yes ☐ No ☐ Unknown
Related Issues ☐ Neuropathy/Nerve Pain ☐ Ulcer History ☐ Slow Healing
Managed by ☐ Primary Care Provider ☐ Other:

Other Contributing Problems ☐ Chronic Pain Syndrome ☐ Fibromyalgia ☐ RA ☐ Other:

Indicate family history of the following ☐ **NONE**	Father	Mother	Sister	Brother
Arthritis				
Cancer				
Diabetes				
Foot Deformity				
Heart Disease				
Hypertension				
Poor Circulation				

Tobacco
☐ Never
☐ Quit _____ (approx. year)
☐ Smoke approx. _____ # of packs per week

Alcohol
☐ Never
☐ Occasionally (less than 1 drink/week)
☐ Moderate (less than 3 drinks/day & 7/week)
☐ Heavy

Weight_____
Height_____

Pregnant
☐ No ☐ Yes, I am currently pregnant _____ weeks

Any Previous Surgeries ☐ **No Past Surgeries** ☐ **List Attached**

Year	Procedure

Past Health History Any history of the following: ☐ None

☐ AIDS/HIV	☐ Edema	☐ Heart Disease	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Anemia	☐ Fibromyalgia	☐ Hepatitis	☐ Lung Disease	☐ Sciatica
☐ Arthritis	☐ Foot Problems	☐ Hernia/Specify	☐ MRSA	☐ Sleep Apnea
☐ Artificial Joints	☐ Frost Bite	☐ Hypertension	☐ Neuropathy	☐ Stroke
☐ Bleeding Disorder	☐ GERD/Heartburn	☐ Insomnia	☐ Organ Transplant	☐ Thyroid Problems
☐ Cancer	☐ Gout	☐ Kidney Disease	☐ Osteoporosis	☐ Tuberculosis
☐ Diabetes	☐ Headaches	☐ Leg/Foot Ulcers	☐ PVD	☐ Varicose Veins

Comments:

Medications

Include OTC, Prescriptions, Supplements & Vitamins

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______________________________________ ☐ I do not take any medications regularly ☐ List attached

Patient Name

Medication *(Name)*	Dose *(mg)*	Form *(tab, capsule)*	Route *(by mouth, inhale)*	Schedule *(1 tab/day, 1 tab twice daily, every 8 hrs)*