FOOT CARE CENTER
Charles F. Markham,D.P.M.

Patient Name:_____
Address:_____ZIP:_____
Home#_____Cell#_____Work#_____
Social Security#_____Date Of Birth____/___/___ Age:_____
Height:_____Weight:_____ Shoe Size:_____
Primary Physician Name_____Physician Phone #_____
Email Address_____Ethnicity:_____Pref Language_____

How were you referred to our practice? _____

What is your current problem with your foot or ankle? _____
_____

Medications: Include name, dosage, vitamins, supplements, ect. NONE_____
1.)_____6.)_____
2.)_____7.)_____
3.)_____8.)_____
4.)_____9.)_____
5.)_____10.)_____

List allergic reactions to any medications and what the reaction is and the severity.
1.)_____2.)_____3.)_____4.)_____

Surgeries/Hospitalizations:Please include type of procedure,date,location and any complications. (For example with Anesthesia) _____
_____
_____
_____

Medical History: Please check the appropriate medical condition. NONE_____

__High Blood Pressure	__Heart Disease	__Liver Disease	__Diabetes
__ Arthritis	__Hepatitis	__Thyroid	__Stroke
__High Cholesterol	__Seizures	__HIV/Aids	__TB
__Sexually Trans. Disease	__Asthma	__Hormones	__Cancer
__Stomach Ulcer/Reflux	__Kidney	__Depression	__Lupus
__Bleeding Disorders/Clots	__Trauma	__Fractures	__Other

Social History: Occupation: _____
Tobacco Products Use: ____No ____Yes If yes,_____pack(s) per day X years.
Alcohol Products: Use: ____Rarely ____Socially ____Daily ____Never
Family History: Are there any medical conditions which run in your family? __No __Yes
If yes, please list:_____
_____

Review of Systems

General:
Recent weight change Y/N
Fever Y/N
Night Sweats Y/N
Change in sleeping habits Y/N
Change in appetite Y/N
Seizures Y/N
Fainting Y/N

Skin:
Rashes Y/N
Pruritus(itching) Y/N
Change is color/size moles Y/N
Bleeding moles Y/N

Head:
Frequent headaches Y/N
History of Trauma Y/N
Dizziness Y/N
Loss of Balance Y/N

Ears:
Change in Hearing Y/N
Decreased hearing Y/N
History of infections Y/N
Vertigo Y/N

Nose,Mouth & Throat:
Nosebleeds Y/N
Sinus Problems Y/N
Tooth Pain Y/N
Dentures Y/N
Recurrent Sore Throat Y/N
Swollen Glands Y/N
Neck Pain Y/N

Eyes:
Vision Problems Y/N
Do you wear glasses? Y/N

Respiratory:
Cough Y/N

Wheezing Y/N
Asthma Y/N
Shortness of breath Y/N

Cardiac:
Chest pain Y/N
Palpitations Y/N
High Blood Pressure Y/N
High cholesterol Y/N
Heart Attack Y/N
Cong.Heart Failure Y/N

GI:
Nausea Y/N
Vomiting Y/N
GI Bleeding Y/N
Bowel Habit changes Y/N
Abdominal pain Y/N
Hepatitis Y/N

Genitourinary:
Frequency Y/N
Urgency Y/N
Bleeding Y/N
Bladder Function Change Y/N

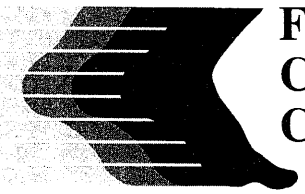
Musculoskeletal:
Arthritis Y/N
Gout Y/N
Swelling Y/N
Stiffness Y/N
Recent Tick Bites Y/N
Lyme Disease Y/N

Vascular/Hematologic:
Varicose Veins Y/N
Deep Venous Thrombosis Y/N
Pulmonary embolism Y/N
Peripheral Vascular Disease Y/N
Raynauds Syndrome Y/N
Easy Bruising Y/N
Easy Bleeding Y/N
Transfusions Y/N

Last Dental Exam? _____

Hand Dominance: Right/Left

Signature:_____Date:_____



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AUTHORIZATION FOR USE & DISCLOSURE OF MEDICAL INFORMATION

PATIENT NAME:_____

DATE OF BIRTH: ___/___/___ TELEPHONE #: _____-_____

AUTHORIZED PERSON(S) TO RELEASE MEDICAL INFORMATION TO:

_____

I authorize Markham Foot & Ankle Clinic to release my medical records including medical information related to the diagnosis as specified below:

MEDICAL INFORMATION

__ Complete Medical Record	__ X-Ray Report	__X-Ray films
__ Demographic/Visit History	__ Labs	__ History & Physical
__ Pathology Reports	__ Operative Reports	__ Consultation Reports
__ Other		

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to office manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year and will only be in effect for visits which have occurred prior to the authorization date unless otherwise specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient/Legal Representative Signature: _____

If you are not the patient, state legal relationship: _____

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