MYRON I. WOLF, D.P.M., FACFAS
PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: _____/_____/_____

PATIENT NAME: _____ _____ _____
FIRST MI LAST
SEX: M F SOCIAL SECURITY # _____-_____- _____

DATE OF BIRTH: ____/_____/____ AGE: ____ E-MAIL: _____

HOME ADDRESS: _____CITY: _____ ZIP: _____

HOME PHONE #: (_____) _____-_____ CELL PHONE #: (_____) _____-_____

EMPLOYER NAME:_____ WORK PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____ PHONE:_____

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

PRIMARY LANGUAGE: _____ **ETHNICITY**: HISPANIC/LATINO NON-HISPANIC/LATINO

RACE: AMERICAN INDIAN ASIAN AFRICAN AMERICAN PACIFIC ISLANDER CAUCASIAN

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____

IF PATIENT IS A MINOR, PARENTS/GUARDIAN
NAME(S)_____
ADDRESS:_____ CITY/STATE: _____ ZIP: _____ PHONE (_____)_____-_____
(IF DIFFERENT FROM THE PATIENT'S ADDRESS ABOVE)

INSURANCE INFORMATION
INSURANCE TYPE (CIRCLE ONE): MEDICARE PPO POS HMO WORK COMP CO-PAY: _____ DEDUCTIBLE: _____
PRIMARY INSURANCE COMPANY NAME: _____
INSURED NAME:_____DATE OF BIRTH:_____ SOCIAL SECURITY # _____

IF COPY OF INSURANCE CARD IS NOT AVAILABLE, PLEASE COMPLETE THE FOLLOWING:
ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (_____) _____-_____
ID # _____GROUP # _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. I UNDERSTAND ALL CO-PAYMENTS AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICE. FURTHER, I WILL BE RESPONSIBLE FOR ALL FEES ASSESSED IF MY ACCOUNT BECOMES PAST DUE. I HEREBY AUTHORIZE ALL INSURANCE PAYMENT DIRECTLY TO WOLF PODIATRY & ASSOCIATES. IN ADDITION, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.

SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

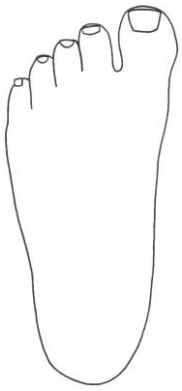
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

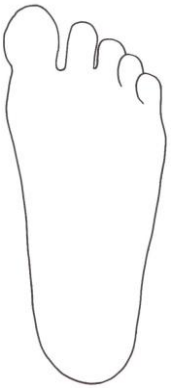
_____

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

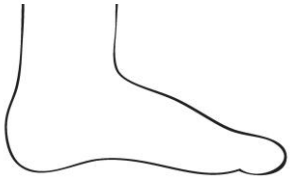
LEFT FOOT



TOP OF FOOT



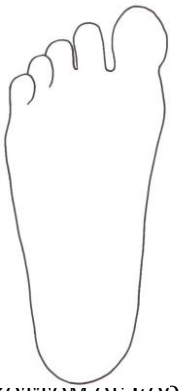
BOTTOM OF FOOT



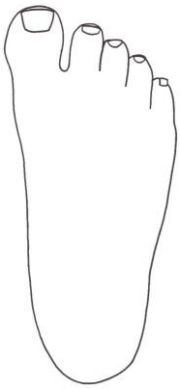
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

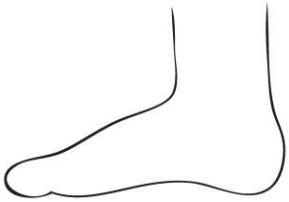


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

CURRENT SHOE SIZE_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

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

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN

☐ MEDICATIONS _____

☐ ANESTHESIA ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE

FOODS _____ ☐ OTHER _____

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 CONDITIONS:								

PHARMACY_____ADDRESS_____PHONE #_____

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 IN THE LAST 3 YEARS:

TYPE OF SURGERY DATE

_____

_____

_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY) IN THE LAST 3 YEARS:

REASON FOR HOSPITALIZATION DATE

_____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

FAMILY HISTORY

SPECIFY FAMILY HISTORY:

CANCER	MOM	DAD
CORONARY ARTERY DISEASE	MOM	DAD
DIABETES	MOM	DAD
HEART DISEASE	MOM	DAD
HIGH BLOOD PRESSURE	MOM	DAD
RHEUMATOID ARTHRITIS	MOM	DAD
STROKE	MOM	DAD
THYROID DISEASE	MOM	DAD
OTHER:		

SOCIAL HISTORY

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

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
CURRENT USE : ☐ 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

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED STUDENT 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) _____ ☐ PETS
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

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

TYPES OF EXERCISE: _____

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 DATE

_____

SIGNATURE (IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT)

_____

DOCTOR SIGNATURE DATE