Foot and Ankle Associates

SINCE 1961

Sports Medicine Center of Excellence

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"We are pledged to improve the quality of life through comprehensive care of foot and ankle disorders. Our team is committed to a relationship based upon care, concern, and compassion."

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Florida Address: _____
Street (Apt. #) City State Zip

Northern Address: _____
(Alternate) Street (Apt. #) City State Zip

S.S. #: _____-_____-_____ Sex: ☐Male ☐Female

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Email: _____ *Facebook?* ☐Yes ☐No *Twitter?* ☐Yes ☐No *YouTube?* ☐Yes ☐No

Ethnicity: _____ Marital Status: _____

Spouse's name: _____ Spouse's employer: _____

Are you a student? ☐Yes ☐No School _____ Grade Level _____

Employer: _____ Occupation & Position: _____

Who may we contact in case of Emergency? _____ Phone _____

*How were you referred to our office? ☐Physician ☐Friend ☐Patient ☐Google ☐Website ☐Internet ☐TV
☐Florida Southern College ☐FitNiche ☐Detroit Tigers ☐Blog ☐Radio ☐ Newspaper
☐Lakeland Runners Club ☐LRMC ☐LeRoy's Bikes ☐Leadership Lakeland/Polk
☐Landsharks Triathlon Club ☐Bent's Cycles ☐Phone Book ☐S.EastnU. ☐Other _____

Referral Source's Name? _____

Primary Care Physician: _____ Phone Number: _____

Would you like a copy of your medical records from our office sent to your Primary Care Physician? ☐Yes ☐No

Do you exercise more than twice a week? ☐Yes ☐No *If yes, complete **Sports Medicine History Form** (Ask at Desk)*

Have you visited our website at: **www.floridafootandankle.com**? ☐Yes ☐No *If not, please visit for great info on foot and ankle conditions, our doctors, our practice, including YouTube videos, blogs, links, and much more!*

I certify that the information given above is true and correct.
I understand that it is my responsibility to notify Foot and Ankle Associates of any changes to the above information.

Patient or Guardian Signature: _____ Date: _____

2939 S. Florida Ave. Lakeland, Florida 33803 863-687-3404

History & Medical Information

When applicable fill-in all blanks, check, or circle all that apply

1. Age: _____ Height: _____ Weight: _____ Shoe Size: _____ **Which foot/ankle/leg is worse:** ☐Right ☐Left

2. **What is your chief complaint with your foot, ankle, or leg?** _____

3. **When did pain/discomfort begin?** _____ Has it: ☐Improved ☐Worsened or ☐Stayed the same
Describe pain/discomfort (circle): Burning Numbness Sharp Dull other: _____
Rate your pain (circle): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

4. **What makes pain/discomfort *better*?** _____

5. **What makes pain/discomfort *worse*?** _____

6. **Has condition been treated?** ☐Yes ☐No If yes, Explain: _____

7. **List all Medications/herbs/vitamins:** ☐None

Medication_____mg____ How often____ Medication_____mg____ How often____
Medication_____mg____ How often____ Medication_____mg____ How often____
Medication_____mg____ How often____ Medication_____mg____ How often____
Medication_____mg____ How often____ Medication_____mg____ How often____

*What is the name/location of your Pharmacy? _____ Phone #_____

8. **Allergies:** ☐None

☐Sulfa Drugs ☐Lidocaine ☐Tetanus ☐Anti-Inflammatories ☐Tape ☐Shellfish
☐Codeine ☐Aspirin ☐Novocaine ☐Sutures ☐Metals ☐Other_____
☐Penicillin ☐Iodine ☐Demerol ☐Radiographic Contrast/ Dyes

9. **Past Medical History:** ☐None

☐Anemia ☐Gout ☐Kidney Disease ☐Other Arthritis
☐Bleeding Disorders ☐Heart Disease ☐Lung Disorders ☐Prostate Disorders
☐Cancer ☐Hepatitis ☐Mitral Valve Prolapse ☐Rheumatic Fever
☐Diabetes ☐High Cholesterol ☐Nerve Disorders ☐Thyroid Disorders
☐Epilepsy ☐HIV/ Aids ☐Neurologic ☐Stroke
☐Osteoarthritis ☐High Blood Pressure ☐Other_____

10. **Surgical History:** ☐None

Surgery/Date/Location:_____ Surgery/Date/Location:_____
Surgery/Date/Location:_____ Surgery/Date/Location:_____
Surgery/Date/Location:_____ Surgery/Date/Location:_____
Surgery/Date/Location:_____ Surgery/Date/Location:_____

11. **Family History:** Circle "*M*" if *M*other's side and/or "*F*" if *F*ather's side ☐None

☐Diabetes *M F* ☐Heart Disease *M F* ☐Bleeding Disorders *M F* ☐Mental Illness *M F*
☐High Blood Pressure *M F* ☐Stroke *M F* ☐Kidney Disease *M F* ☐Cancer *M F*
☐Rheumatology *M F* ☐Foot Problems____*M F*____ ☐Other Family History: _____

12. **Social History:** **Are you:** ☐**Pregnant** ☐**Nursing**

Tobacco Use? ☐Yes ☐No If yes how much? _____ Have you ever smoked? ☐Yes ☐No
Chewing Tobacco? ☐Yes ☐No If yes how much? _____ Caffeine Use? ☐Yes ☐No
Alcohol Use? ☐Yes ☐No If yes how much? _____ Drug Use (recreational, IV)? ☐Yes ☐No
*Exercise Regularly? ☐Yes ☐No If yes, how many hours per week? _____

The American College of Sports Medicine (ACSM) recommends a minimum of **30 minutes exercise on **5 days per week.***

Review of Systems

Check all that apply

Constitutional Symptoms: ☐None

☐Fever/Chills ☐Sweats ☐Weight Loss

1. Eyes: ☐None

☐Contacts ☐Eyeglasses ☐Double Vision ☐Cataracts

2. Head, Eyes, Ears, Nose and Throat: ☐None

☐Dentures ☐Dizziness ☐Ringing in Ears ☐Neck Pain

☐Sore Throat ☐Nose Bleeds ☐Difficulty Swallowing

3. Integumentary: ☐None

☐Rash ☐Skin Ulcers ☐Lesions ☐Sensitivity to Sun

☐Change in Skin Color ☐Growth on Skin ☐Recurrent Infections ☐Eczema

☐Cracking of the Skin ☐Keloid ☐Hair Loss

4. Allergies: ☐None

☐Sulfa Drugs ☐Lidocaine ☐Tetanus ☐Anti-Inflammatories ☐Tape ☐Shellfish

☐Codeine ☐Aspirin ☐Novocaine ☐Sutures ☐Metals ☐

Other_____ ☐Penicillin ☐Iodine ☐ Demerol ☐Radiographic Contrast/ Dyes

5. Musculoskeletal: ☐None

☐Tendonitis ☐Broken Bones ☐Arthralgia ☐Weakness Of limbs

☐Feeling Weak ☐Joint Pain ☐Bursitis

6. Nervous System: ☐None

☐Migraines ☐Seizures ☐Strokes ☐Nervous Disorders

☐Ataxia (loss of balance) ☐Aphasia ☐Loss of speech ☐Confusion

☐Neuropathy (loss of sensation) ☐Speech Difficulties ☐Fainting

7. Endocrine: ☐None

☐Often Thirsty ☐Often Urinating ☐Kidney Disease ☐Pancreatitis

☐Thyroid Disorder ☐Diabetes Mellitus ☐Prostate Problems

8. Respiratory: ☐None

☐Shortness of Breath ☐Emphysema ☐Cough Bronchitis ☐Wheezing

☐Difficulty Breathing ☐Asthma ☐Previous Pulmonary Disease

☐TB (tuberculosis) ☐Pneumonia ☐Exposure or Treatment

9. Gastrointestinal: ☐None

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

☐Stomach ☐Ulcers ☐Decrease in Appetite ☐Blood in Stool

☐Hepatitis ☐Acid Reflux

10. Cardiovascular: ☐None

☐Chest Pain/Heart Attack ☐Congestive Heart Failure ☐Leg Pain w/ Exercise

☐Heart Murmur Palpitations ☐Swelling in Legs/Ankles ☐Cardiovascular Surgery

11. Hematological/Lymphatic (blood): ☐None

☐Bleeding abnormalities ☐Anemia Lump in Groin or Armpit Lymphoma ☐Swollen Glands

12. Psychiatric: ☐None

☐Nervousness ☐Tension ☐Depression

13. Is there anything else we should know?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ Date: _____

Insurance Policies and Privacy Practices

Patient Name: _____ Date: _____

Insured's Name: _____ Date of Birth: _____

Insured's Relationship: _____

- 1. I request that payment of authorized insurance benefits be made on my behalf to Foot and Ankle Associates. I authorize any holder of medical information about me to be released to my insurance company any information needed to determine these benefits for related service. I also accept responsibility for any deductible, percentage, co pay, or non-covered items, out of network penalties or collections costs that I may encounter. _____ **(Initial)**

- 2. I understand that the Foot & Ankle Associates will bill my secondary insurance ONE TIME as a COURTESY. If payment has not been received within 45 days the balance will be my responsibility. _____ **(Initial)**

- 3. I understand that it is my responsibility NOT the Foot & Ankle Associates for knowing if they are a participating provider with my insurance company, I also understand that I am responsible for obtaining any required referrals and will be held responsible for charges not paid due to failure to obtain said referral. _____ **(Initial)**

- 4. I will be paying my co-pays/deductibles or anything not covered by my insurance by:
☐Cash ☐Check ☐Credit Card

- 5. There is a $30 fee for all returned checks and a $25 fee if I do not give 24 hour notice for cancellations. _____ **(Initial)**

- 6. Acknowledgement of **HIPPA** Guidelines (Notice of Privacy Practices)
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. **
****HIPPA packets are available at the front window.** _____ **(Initials)**

- 7. With whom may we leave a message if you are unable to answer:
☐Patient only ☐Patient/Spouse ☐Anyone answering the phone

- 8. May we leave lab, testing results, appointment reminders & surgical procedure dates on your answering machine/voice mail? ☐**YES** ☐ **NO**

- 9. Whom may we share your health information if you are unavailable?
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

- 10. I hereby give permission to Drs. Odro, Fazekas, and Werd, to treat my lower extremity condition.

Patient or Guardian Signature: _____ Date: _____

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____

Date:_____

Circle "Yes" or "No":

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No
2. Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No
3. Do you experience foot or toe pain that often disturbs your sleep?	Yes	No
4. Are your toes or feet pale, discolored or bluish?	Yes	No
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No
7. Have you suffered a severe injury to the leg(s) or feet?	Yes	No
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No

Patient Signature:_____

Physician Signature:_____ Date: _____

Fall Risk Assessment Form

**Please circle the appropriate number for each parameter*

PARAMETER	SCORE	PATIENT STATUS/CONDITION
Vestibular *(Dizziness)*	0.....	No Complaints of dizziness
	6.....	Intermittent complaints of dizziness
	10....	Dizziness that interferes with ADLs
History of Falls *(past 12 months)*	0.....	No falls
	6.....	1-2 falls or near falls
	10....	3 or more falls or near falls
Peripheral Neuropathy *(Proprioception)*	0.....	No sensory deficits
	2.....	Peripheral neuropathy (diminished proprioception)
	4.....	Profoundly neuropathic
Vision Status	0.....	Adequate (w/or w/o glasses)
	2.....	Poor (w/ or w/o glasses)
	4.....	Legally Blind

Gait and Balance **Stand on both feet without any type of assistance; then, walk forward, through a doorway; then, make a turn. (Mark all that apply.)*

0.....	Normal/ safe gait and balance
2.....	Balance problem while standing
2.....	Balance problem while walking
2.....	Decreased muscular coordination
2.....	Change in gait pattern when walking through a doorway
2.....	Jerking or unstable when making turns
2.....	Requires assistance (person, furniture/walls, or device)

Ankle Strength/ Range of Motion *(Postural Control)*	0.....	Normal ankle strength & range of motion within normal limits
	2.....	Moderate limitation of ankle joint range of motion & strength
	4.....	Significant ankle joint instability and weakness

Medications **Based upon the following types of medications: anesthetics, antihistamines, cathartics, diuretics, antihypertensives, antiseizure, benzodiazepines, hypoglycemics, psychotropics, sedative/hypnotics.*

0.....	None of these medications taken currently w/in past 7 days
2.....	Takes 1-2 of these medications currently or w/in past 7 days
4.....	Takes 3-4 of these medications currently or w/in past 7 days
1.....	Any change in these medications or doses in past 5 days.

Predisposing Diseases **Based upon the following conditions: neuropathy, hypertension, vertigo, CVA, Parkinson's Disease, loss of limb(s), seizures, arthritis, osteoporosis fractures. (M0210, M0230, M0240)*

0.....	None present
2.....	1-2 present
4.....	3 or more present

Get Up and Go	0.....	Able to rise in a single motion (no loss of balance with steps)
	2	Pushes up, successful in one attempt
	6.....	Multiple attempts to get up, but successful
	10....	Unsuccessful or needs assistance
Walk and Talk	0.....	No deficit in walking while speaking
	6.....	Inability to maintain normal gait pattern while speaking
	10....	Must stop walking in order to speak
Foot Deformity	0.....	No foot deformity
	2.....	Presence of foot deformities (eg corns, bunions, swelling)
Footwear	0.....	Wearing supportive, appropriate footwear
	2.....	Inappropriate, poorly-fitted or worn footwear

TOTAL POINTS:

0-9 Low Fall Risk ***10-20 High Fall Risk*** ***>20 Extreme Fall Risk***