Foot Health Center, LLC
1500 Pleasant Valley Way, Suite 204
West Orange, NJ 07052
973-731-1266

PATIENT REGISTRATION FORM

Today's Date: _____

Primary Physician: _____ Referral Source: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Birth Sex (M/F): _____ Social Security #: _____

Street Address: _____ City/State/Zip: _____

Home Telephone: _____ Cell Number: _____ Work Number: _____

OK to leave message with personal health info.? PatientMessagesOK *OK to leave text message? PatientTextsOK*

Email: _____ Driver's License # (State): _____

Race (American Indian/Asian/Black or African-American/Hawaiian/White/Other): _____

Ethnicity (Hispanic/Non-Hispanic): _____

Marital Status: _____ Name of Spouse (if married): _____

Emergency Contact (Name & Telephone): _____

Employer: _____ Occupation: _____ Requesting Chaperone to be present in Exam Room:Y / N

Interpreter/ Translator Needed: Spanish_____ American Sign Language_____Other_____

Do you have medical insurance: ❑Yes ❑No

PRIMARY INSURANCE INFORMATION

Primary Insurance Name: _____

Policy ID #: _____ Group/Plan #: _____

Insurance Address _____

Copay (amount): _____ Deductible (amount and if met): _____ Coinsurance: _____

Referral (if needed, please supply number): _____

What is your relationship to Policy Holder? ❑Self ❑Spouse ❑Child

Policy Holder Information (if different from patient):

Name: _____ Address: _____

Home Phone #: _____ Cell #: _____ Work Phone #: _____

Date of Birth: _____ Social Security #: _____ Sex: ❑Male ❑Female

SECONDARY INSURANCE INFORMATION

Secondary Insurance Name: _____

Policy ID #: _____ Group/Plan #: _____

Insurance Address: _____

Copay (amount): _____ Deductible (amount and if met): _____ Coinsurance: _____

Referral (if needed, please supply number): _____

What is your relationship to Policy Holder? ❑Self ❑Spouse ❑Child

Policy Holder Information (if different from patient):

Name: _____ Address: _____

Home Phone #: _____ Cell #: _____ Work Phone #: _____

Date of Birth: _____ Social Security #: _____ Sex: ❑Male ❑Female

---

For Minors: Please indicate responsible Parent/Guardian: _____

If financially responsible party has different mailing address, please indicate:

Responsible Party Name (if different than patient): _____

Address: _____

Phone #: _____ Date of Birth: _____ Social Security #: _____

Relationship to patient: _____

COMMUNICATION PREFERENCES:
I understand that the staff and /or physicians of Foot Health Center, LLC may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Contact Preference (Home/Cell/Work): _____ Preferred Language: _____

If you *do not wish to have courtesy reminder calls for upcoming appointments, please be aware that there is a cancellation fee of $25.00 if not cancelled within 24 hours, please initial* _____

CONSENT TO DISCUSS HEALTH CARE:
I AUTHORIZE THE STAFF AND/OR PHYSICIANS OF FOOT HEALTH CARE, LLC TO DISCUSS MY HEALTH CARE INFORMATION WITH THE INDIVIDUALS LISTED BELOW. I understand that I am not required to list anyone. I also understand that I may change the list in writing anytime.

NAME:_____RELATIONSHIP:_____DOB:_____PHONE #:_____

NAME:_____RELATIONSHIP:_____DOB:_____PHONE #:_____

AUTHORIZATION TO ACCESS ELECTRONIC PRESCRIPTION RECORDS:
I authorize Foot Health Center, LLC to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Foot Health Center, LLC medical record. My signature below certifies that I authorize the access to my prescription records.

PHOTOGRAPH RELEASE FOR MEDICAL RECORDS: ❑YES ❑NO
I hereby authorize and consent to the taking of photographs and moving pictures of me by Foot Health Center, LLC, its agents or employees. I hereby authorize and consent to the use of such photographs and moving pictures for identification purposes in my medical record.

I hereby release Foot Health Center, LLC its medical staff, agents, and employees from all liability related to the making and use of such photographs and moving pictures for the purpose stated above.

RELEASE AND ASSIGNMENT OF BENEFITS:
I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers of Foot Health Center, LLC for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize Foot Health Center, LLC or any other holder of medical or other information about me to release to Medicare, Medicaid, Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

CONSENT TO TREAT:
I, the undersigned, voluntarily consent to and authorize Foot Health Center, LLC through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests and treatments as are considered necessary or advisable, in my diagnosis, care, and treatment, in the judgment of my Foot Health Center, LLC physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

ACKNOWLEDGEMENTS AND AGREEMENT:

- I acknowledge receipt of the Foot Health Center, LLC Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices, and agree to all the terms and conditions contained therein (unless I have opted out alone).
- I agree to allow access to my electronic prescription records as described above.
- I acknowledge receipt of Foot Health Center, LLC Electronic Mail (e-mail) Policy, and agree to all the terms and conditions contained therein.
- I agree to the release and assignment of benefits as described above.
- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

Patient/Representative's Signature: _____ Date: _____

IF YOU ARE UNDER 18 YEARS OF AGE WE WILL NEED A PARENT SIGNATURE.

IF SIGNED BY AUTHORIZED REPRESENTATIVE, PRINT NAME: _____

RELATIONSHIP TO PATIENT/AUTHORITY TO SIGN: _____

Please present primary and secondary insurance card(s) so we may make a copy, along with your driver's license or valid photo identification. If you do not have your card, you will be responsible for services rendered at that time, due to the overwhelming number of addresses for each insurance company and the necessity of having your ID#. As well, if a referral is needed, you need to supply it at time of visit. Please take note this office will only submit to two insurances. If this is workers compensation, auto claim, or claims going to your lawyer, please supply that information on date of service. But please take note, you will ultimately be responsible for the bill.

Please be aware it is your responsibility to be aware if your insurance does not cover benefits for podiatry services or a particular service or treatment (diagnosis/billing code), under your plan. We strongly suggest that you call your insurance so that you understand your benefits and coverage, and the insurance's disclaimer that they **DO NOT GUARANTEE PAYMENT**, not even with an authorization.

Some insurances are just administrators and actual coverage or if we are in network may be different. So please call your insurance on the back of the card under member services to verify if we are on your plan and what your benefits/coverage includes for services, treatments, and durable medical equipment if necessary. When you call insurance, please make note with whom you spoke and reference #, as we do, in case needed for appeals. But please be aware we will do all that is required for appeal on our behalf, but you may have to call and send written documentation to your insurance as well. If appeal is unsuccessful, you are ultimately responsible for any services or products.

Please follow up with your insurance on any Coordination of Benefits (COB) so your claim is not denied in which you will receive a bill.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM(S) AND HEREBY ASSIGN FOOT HEALTH CENTER, LLC (DR. MICHAEL VERDI, DR. KIRSTEN DISCEPOLA, DR. DOUGLAS N. DELORENZO, Dr. MERIHAN BOTROS AND DR. PATRICIA BERRAN) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO SELF OR DEPENDENTS.

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES FOR ALL OF THE SERVICES AND/OR PRODUCTS RENDERED TO ME OR ANY MEMBER OF MY FAMILY.

ALTHOUGH I HAVE REQUESTED THE DOCTOR TO BILL MY INSURANCE ON MY BEHALF, I CLEARLY UNDERSTAND THAT IF A BILL IS NOT PAID BY MY INSURANCE WITHIN A TIMELY MANNER, I AGREE TO MAKE ARRANGEMENTS FOR PROMPT PAYMENT TO FOOT HEALTH CENTER, LLC.

I AGREE TO HAVE A VALID REFERRAL (IT IS THE POLICYHOLDER'S RESPONSIBILITY TO KNOW IF INSURANCE REQUIRES REFERRAL) FOR VISIT AND ANYTIME INSURANCE CHANGES. Please supply updated or new insurance cards as you receive them.

PLEASE NOTE: IF YOU HAVE NO INSURANCE YOU WILL BE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICES.

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at **www.foothealthcenter1.com** or calling the Privacy Officer at **973-731-1266**.

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at **973-731-1266**, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Foot Health Center,LLC

Michael V. Verdi,DPM,FACFAS
Patricia A. Berran, DPM, FACFAS
Merihan Botros,DPM
Kirsten Discepola, DPM
Douglas N. DeLorenzo,DPM,FACFAS

1500 Pleasant Valley Way
Suite 204
West Orange, NJ 07052
973-731-1266
Fax 973-731-1712

Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Revised: March 25, 2013

Privacy Officer:Robin Verdi,RN,BSN
rverdi@foothealthctr.com

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

PATIENT CONSENT FOR USE OF ELECTRONIC MAIL

Patient name: _____
Patient address: _____
Account Number: _____
Patient email: _____

1. RISK OF USING E-MAIL

Foot Health Center, LLC offers patients the opportunity to communicate with clinicians by e-mail, you will also have access to our Patient Portal on our website www.foothealthcenter1.com. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.
c. E-mail senders can misaddress e-mail.
d. E-mail can be more easily falsified than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Foot Health Center, LLC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Foot Health Center, LLC cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel will have access to those e-mails.
b. Foot Health Center, LLC may forward e-mails internally to Foot Health Center's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Foot Health Center will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Foot Health Center, LLC will endeavor to read and respond promptly to e-mail from the patient, Foot Health Center, LLC cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
d. If the patient's e-mail requires or invites a response from Foot Health Center, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability, or substance abuse.
f. The patient is responsible for informing Foot Health Center of any types of information the patient does not want to be sent by e-mail, in addition to those set out in (e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. Foot Health Center is not liable for breaches of confidentiality caused by the patient or any third party.
h. Foot Health Center shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform Foot Health Center of changes in his/her e-mail address.
c. Put his/her name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing questions).
e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to the Provider.
f. Inform Foot Health Center that the patient received e-mail from Foot Health Center.
g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to the Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Signature _____

Date: _____

Witness Signature: _____

Date: _____

TELEPHONE CONSUMER PROTECTION ACT
PRIOR EXPRESS CONSENT

Foot Health Center, LLC
1500 Pleasant Valley Way, Suite 204
West Orange, NJ 07052
973-731-1266
www.foothealthcenter1.com

The Telephone Consumer Protection Act (TCPA) prohibits a person or company from making any call using any automatic telephone dialing system or an artificial or prerecorded voice to any wireless telephone number unless the call is made for an emergency purpose or the call is made with the prior express consent of the called party.

Through this Prior Express Consent, I consent to allow Foot Health Center, LLC to contact me through automated technology at my mobile phone:_____(**mobile phone number**).

I agree to allow Foot Health Center, LLC to contact me regarding products or services related to my medical care.

I understand that my medical care is not conditioned on my acceptance of this Prior Express Consent.

_____ _____
Patient Date

_____ _____
Witness Date

FOOT HEALTH CENTER, LLC
1500 Pleasant Valley Way Suite 204 West Orange NJ 07052
973-731-1266

PATIENT HEALTH HISTORY FORM

Name: _____ **Date:** _____

Gender (M/F): _____

Name of Primary Care Physician (Address and Phone # if known): _____

Pharmacy Name: _____

Pharmacy Address & Phone#: _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Please list ALL medications you are taking (prescriptions and/or over the counter): _____

_____

Do you have any Allergies? (Food/Drugs/Latex/Seasonal) _____

If yes, what is your reaction? _____

Chief Complaint/Concern: _____

_____

Where is your pain located: ❑Right ❑Left (check)_____

Describe your pain (check those that apply):
❑Sharp ❑Burning ❑Shooting ❑Achy ❑Knifelike ❑Twisting ❑Pressure ❑Toothache ❑Deep ❑Heavy ❑Gnawing ❑Throbbing ❑Dull ❑Pulsating

How long have you had pain? _____

What makes pain worse? _____ **What makes pain better?** _____

What medications have you taken for your pain? _____

How severe is your pain? _____
0 (no pain), 1-2 (tolerate without medication), 3-4 (tell someone about my pain, take aspirin or Motrin), 5-6 (mild narcotic, ex. Tylenol #3, 7-8 (go to the emergency room, take strong narcotic), 9-10 (admission to the hospital for pain control)

Immunizations	Up to Date?		Date of Last Shot
Covid-19	❑Yes	❑No	
Influenza	❑Yes	❑No	
Tetanus	❑Yes	❑No	
Pneumonia	❑Yes	❑No	

Name: _____ **Date:** _____

PAST MEDICAL HISTORY (Please check any that apply)

❑Hypertension ❑High Cholesterol
❑Pre-Diabetes Diabetes: ❑Insulin Dependent **or** ❑Non-Insulin Dependent Recent HBA1C (and date)_____
❑Peptic Ulcer ❑Cancer ❑Back Injury ❑Arthritis ❑Asthma
❑Gastric Reflux ❑Heart Disease ❑Angina ❑Arrhythmia ❑Mitral Valve Prolapse ❑Seizures ❑HIV ❑Hepatitis
❑Gout ❑Sickle Cell Disease ❑Kidney Disease ❑Other _____
Past Surgeries (dates):_____
Non-Surgical Hospitalizations:_____

Social History:
Type of Job/Occupation_____
Do you smoke? ❑ Current ❑Never ❑Former If yes, how many packs/day? For how many years? _____
❑Cigarettes ❑Cigars ❑Vaping
Do you use drugs (illegal or prescription misuse)? ❑Never ❑ Past ❑ Current
Do you consume alcohol? ❑ Yes ❑No If yes, how much/often?_____

Do you have an Advance Care Plan? ❑ Yes ❑ No On file ❑ Surrogate Decision Maker_____

Any falls in past year? ❑ Yes ❑ No If yes, how many times? _____ Were you injured? _____
Worried about falling? ❑ Yes ❑ No Feels unsteady when standing or walking? ❑ Yes ❑ No
Who do you live with?_____ How many stairs:_____
Do you exercise? ❑ Yes ❑ No If yes, type of exercise_____ How long do you exercise_____ How often_____

Review of Systems: Please circle any that apply:

CONSTITUTIONAL: weight change, weakness, fatigue, fever
EYES: glasses, pain, tearing, double vision
EARS, NOSE, MOUTH, AND THROAT: tinnitus, dizziness, pain, sinus, colds, sore throat
CARDIOVASCULAR: high blood pressure, rheumatic fever, murmurs, shortness of breath, chest pain, palpitations
RESPIRATORY: cough, sputum, coughing up blood, wheezing asthma, bronchitis, chest pain, breathing problems
GASTROINTESTINAL: difficulty swallowing, heartburn, vomiting, diarrhea, indigestion, pain, blood, stool changes
GENITOURINARY: pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence
SKIN: rash, lumps, itching, dryness, color changes, hair changes, nail changes
NEUROLOGICAL: fainting, blackouts, seizures, paralysis, memory loss
PSYCHOLOGICAL: nervousness, tension, mood changes, depression, anxiety
ENDOCRINE: heat or cold intolerance, sweating, thirst, hunger, change in urination
HEMATOLOGY/LYMPHATICS: bruising, bleeding, transfusion reactions
ALLERGIES/IMMUNOLOGICAL: drug, product, or other allergies
REPRODUCTIVE: sexual dysfunction, pregnancy
MUSCLE/SKELETAL: back, joint, or muscle pain

Comments: _____

_____ Date: _____