Record ID # 226055

DOCUFORMS™ POD-2010
Confidential Office Medical Record

☐ Only Changes To The Previous History Information Are Noted

☐ INITIAL HISTORY ☐ UPDATE OF HISTORY TAKEN

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct # Staff Entry

First Name: MI: Last Name:

Your type of Job Activity / Occupation:

☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr.

Last 4 digits of Socal Sec. #: Sex M / F Age Birth Date: / /

Shoe Size: Weight: Height:

☐ I prefer to be addressed by: ○ First Name ○ Nick Name:

Phone Numbers For Contacting You:
Day: ( ) -
Evening: ( ) -
Cell/Pager: ( ) -

In Case of Emergency, Please Call:
Day: ( ) -
Evening: ( ) -

Please Provide Your Preferred Pharmacy:
Street / City:
Day: ( ) -

2 COMPREHENSIVE PATIENT MEDICAL HISTORY ROS/PFSH

Have you had/been treated for:
☐ Warts ☐ Athlete's Foot
☐ Corns/Calluses ☐ Fungal Nails ☐ Ingrown nails
☐ Leg or Foot Ulcers ☐ Neuroma ☐ Foot Numbness
☐ Broken foot bone(s) ☐ Broken Ankle ☐ Ankle sprain
☐ Hammer/Mallet toes ☐ Bunions ☐ Flat feet
☐ Cramps in legs/feet ☐ Arch pain ☐ High arch feet
☐ Lower back pain ☐ Knee pain ☐ Heel pain
☐ Gait (Walking) problems ☐ In-toeing ☐ Toe walking
☐ Childhood foot problems ☐ Rash ☐ ***NONE of these***

Did you previously or do you now wear:
Shoe inserts? [Y] [N] Still using them? [Y] [N] Do or did they help? [Y] [N]
Orthotics? [Y] [N] Still using them? [Y] [N] Do or did they help? [Y] [N]
The orthotics were obtained from: ○ Another Podiatrist ○ An Orthopedist
○ A Physical Therapist ○ A Chiropractor ○ Other:

Are your first steps out of bed painful? [Y] [N] ... then subsides? [Y] [N]
Do you get leg cramps ...during the Day? [Y] [N] ...at Night? [Y] [N]
Percent of waking hours spent on your feet? [20%] [40%] [60%] [80%] [100%]

List the sports/type of dance your are active in:

Does foot pain limit your desired activities? ☐ Yes ☐ No
Do you have any difficulty in walking? ☐ Yes ☐ No
Any pain in calves or buttocks when walking? ☐ Yes ☐ No
Is the pain relieved by stopping & standing still? ☐ Yes ☐ No

Do you have or have you ever been treated for:
☐ Stroke ☐ Heart Attack ☐ High Blood Pressure
☐ Phlebitis ☐ Vascular Disease ☐ A Heart Condition
☐ Anemia ☐ Poor Circulation ☐ Eyes:Glaucoma/Manicular Deg.
☐ Diabetes ☐ Kidney Disease ☐ Keloid/Thick Scar
☐ Gout ☐ Osteoporosis ☐ Alzheimer's
☐ Sciatica ☐ Lyme's Disease ☐ Rheumatic Fever
☐ Arthritis ☐ Headaches ☐ Hearing/Ear Disorder
☐ Epilepsy ☐ Nerve Disorder ☐ Psychiatric Disorder
☐ Asthma ☐ Lung Disease ☐ Tuberculosis
☐ Hepatitis ☐ Liver Disease ☐ Thyroid Problem
☐ Dark Urine ☐ Chronic Light Stool ☐ Unexplained Weight Loss
☐ Cancer ☐ Stomach Ulcer ☐ ***NONE of these***
☐ Other(s):

Do you have vascular grafts? (*If yes, explain below*) ☐ Yes ☐ No
Do you have joint implants? (*If yes, explain below*) ☐ Yes ☐ No
Do you have replacement heart valves? ☐ Yes ☐ No
Are you now under active chemotherapy? ☐ Yes ☐ No
Have you had any other serious illness? (*List below*) ☐ Yes ☐ No
Have you had any surgery? (*If yes, explain below*) ☐ Yes ☐ No
Have you ever been hospitalized or been under medical care over 24 hrs? (*If yes, explain below*) ☐ Yes ☐ No

I Had Surgery for: on date of: w/ complications of:

List relationship to you of family members who have had:
Diabetes Foot Problems
Arthritis Heart Attack
Stroke High Blood Pressure
Cancer Birth Defects

# of childbirths ___ Are you currently pregnant? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Do you smoke now? ☐ No ☐ Yes Packs/day ___ Years___
Did you ever smoke? ☐ No ☐ Yes Packs/day ___ Years___
If you quit, when did you do so?
Alcoholic beverages? (Circle one) None Rarely Moderately Daily Quit
Recreational Drugs? (Circle one) None Rarely Moderately Daily Quit
Please mark if you take vitamins or supplements that contain ○ *garlic,* ○ *Gingko biloba,* ○ *echinacea,* ○ *ginseng or* ○ *St. John's Wort*
Are you currently taking any medications? List below! ☐ Yes ☐ No
Are you taking Insulin? If yes, list below. ☐ Yes ☐ No

When noting frequency: A = As needed, x/ = times per D = day, W = week,

List: Medications	Dose?	How Often?	For Treatment of?
		[A], x/[D][W],	
		[A], x/[D][W],	
		[A], x/[D][W],	
		[A], x/[D][W],	
		[A], x/[D][W],	

Are you taking your medications as prescribed? ☐ Yes ☐ No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of: *(Check the answer box that applies)*

	No	Yes	If yes, what happens?
Latex, Adhesive tape *(circle)*	☐	☐	
Penicillin	☐	☐	
Other antibiotics *(list below)*	☐	☐	
Empirin, Tylenol *(if yes, circle)*	☐	☐	
Aspirin, Advil, Aleve, or Motrin *(circle)*	☐	☐	
Celebrex	☐	☐	
Other pain remedies *(list below)*	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics *(list below)*	☐	☐	
Novocaine	☐	☐	
Other anesthetics *(list below)*	☐	☐	
Sulfa drugs	☐	☐	
Shrimp, Iodine, or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Others:

Anything else that you want to tell the doctor? ☐ Yes ☐ No
Illnesses/Explanations:

PATIENT HISTORY AS OF ___/___/___

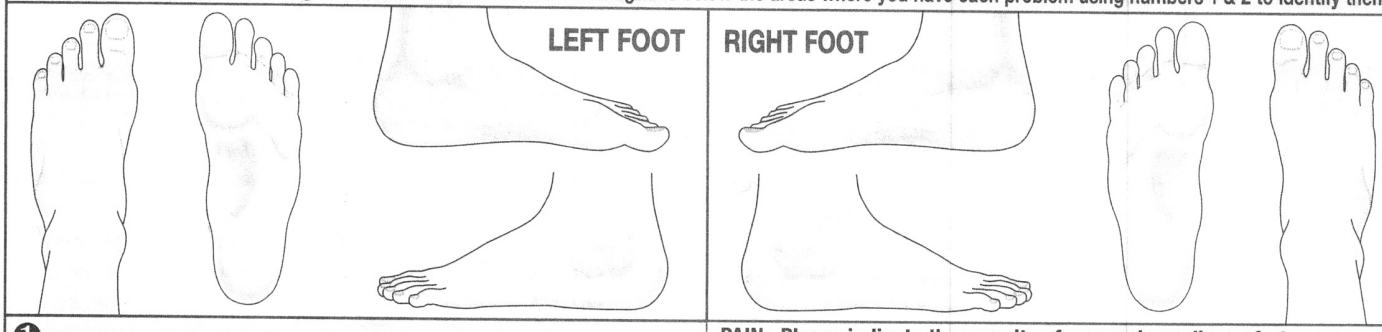
PLEASE CONTINUE ON THE OTHER SIDE TO PROVIDE ADDITIONAL DETAILS.

Patient CC# (s)

3 PATIENT'S CURRENT CHIEF COMPLAINTS CC/HPI

Patient CC# (s)

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.



1 Please mark the location of your first problem or pain on the diagrams above with a number **1**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My first problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

_____

_____

_____

_____

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
0 None. . . . 1 Light . . . 2 Moderate . . . 3 Strong . . . 4 Severe

My Pain/Discomfort is:
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

How long ago did the problem (pain) start?:

_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:

☐ while walking and/or ☐ while not walking

☐ and/or: _____

Previous medical treatment(s) or home remedies:

_____

_____

_____

2 Please mark the location of your second problem or pain on the diagrams above with a number **2**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My second problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

_____

_____

_____

_____

_____ Is problem work related? Y N

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort:
0 None. . . . 1 Light . . . 2 Moderate . . . 3 Strong . . . 4 Severe

My Pain/Discomfort is:
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

How long ago did the problem (pain) start?:

_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:

☐ while walking and/or ☐ while not walking

☐ and/or: _____

Previous medical treatment(s) or home remedies:

_____

_____

_____

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:		
Family/ Primary				__/__/__	Y N	2nd Opinion	Surgcl Eval	Consult
Specialist				__/__/__	Y N	2nd Opinion	Surgcl Eval	Consult
Other Podiatrist				__/__/__	Y N	2nd Opinion	Surgcl Eval	Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

☐ Patient was ○ assisted in completion of this record by or was ○ unable to complete without the help of: _____.

☐ Translation was done by _____ in ○ Spanish, ○ _____.

☐ Additional Information† obtained from ○ Family/Care givers and/or ○ Physician(s) _____

☐ Lab Reports† and/or ☐ Previous Medical Records† were reviewed. ☐ X-rays† brought by patient from _____ were reviewed.

† Elaborations: _____

_____

_____

_____

_____

I have reviewed the information provided above _____. ☐ My annotations to patient's entries are marked in: _____ (INK COLOR)

Doctor's Signature X _____ Date / / MP ☐ See Additional Documentation

Record ID # 226055

Confidential Office Medical Record

☐ QA Review by_____ on ____/____/____

☐ Only Changes To The Previous History Information Are Noted

PATIENT HISTORY

Patient Name Last, First, Middle _____

Medical Record # or Last 4 Digits of SSN _____ Sex ___ Age ___ DOB __/__/__

2010

DO NOT COPY BLANK FORMS. ORIGINAL FORMS WILL HAVE A MATCHING UNIQUE RED SERIAL NUMBER OVER MICROPRINT ON BOTH SIDES OF FORM

Steven K. Shoemaker DPM & Assoc, Inc.

1421 Secret Ravine Parkway, #111
Roseville, CA 95661
Phone: (916) 781-3223
Fax: (916) 781-8171

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient right section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change, If we change our notice you may obtain a revised copy by contacting our office.

I have been given the right to review the Notice of Privacy Practices prior to signing this consent. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this practice is not required to agree to my requested restrictions, but if it does then this practice is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any timey, except to the extent that this practice has taken action relying on this consent.

Patient Name: _____

Signature:_____

Relationship to Patient
(If other than patient):_____

Date:_____

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Please initial each item and sign at the bottom:

____Assignment of benefits: I agree to assign my health insurance and third party benefits to Podiatry and Ankle Care or to Steven Shoemaker DPM

____I agree to pay what my insurance company does not pay including deductible amounts, as well as any collection costs which may occur.

____I consent to examinations. All treatments, procedures, including surgical will be explained and need consent. I will address my concerns to Dr. Shoemaker.

____I accept responsibility for my actions and will follow the direction I am given.

____I understand the doctor cannot warranty or guarantee medical treatment, procedures, or diagnoses.

____I will cancel return appointments 48 hours prior of the appointment. There will be a no show office visit fee. I will pay this fee which is a minimal charge of $50.00. I also realize that sometimes the doctor may have to change my appointment to accommodate urgent surgical needs or emergency treatment of other patients.

____Arbitration agreement: I agree to settle care disputes directly with the doctor. If that fails, I agree to binding arbitration instead of a trial with jury. I will wait for one year to allow the body to heal, as many problems resolve with time.

____I agree to provide Dr. Shoemaker a complete medical history, I agree to hold him harmless for facts omitted and not updated. We need this information because your foot is attached to the rest of you.

____I will not be rude to the staff. I understand this behavior and non-payment are grounds to be discharged as a patient from this practice.

____Please let us know if anything about your visit was not satisfactory prior to leaving. We want to know how we can better help you or your family.

I understand and agree to the above:_____Date:_____

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Roseville, CA 95661
Phone: (916) 781-3223
Fax: (916) 781-8171

Patient Name: _____

I hereby instruct and direct my insurance company_____ to pay by check made out and mailed to Dr. Steven Shoemaker, DPM at 4120 Douglas Blvd., #306-165, Granite Bay, CA 95746 or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make the check to me and mail it as follows:

C/o Steven Shoemaker, DPM
4120 Douglas Blvd. #306-165
Granite Bay, CA 95746

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNEMNT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my vase to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Date at Roseville, California this ___day of _____, 20___.

X_____ _____
Signature of Policyholder Witness

_____
Signature of claimant, if other than policyholder

Patient authorizes the doctor to deposit checks received on patient's account when made out to the patient.

X_____ _____
Signature Date