LEDESMA
FOOT + ANKLE

NEW PATIENT QUESTIONNAIRE

Patient Information

Patient Name:_____ **Date of Birth:**_____ **Age:**_____

Mailing Address:_____ **City:**_____

State:_____ **Zip Code:**_____ **Home Phone #:**_____ **Height**_____ **Weight**_____

Cell Phone #:_____ **E-mail:**_____ **SSN#**_____

Preferred method of contact from our office: [ ] e-mail [ ] home phone [ ] cell phone [ ] mail

Are you the primary policy holder of your insurance? [ ] Yes [ ] No

If no, what's the primary policy holder's name? _____

Date of Birth:_____ **Relationship of the policy holder to you?**_____ **SSN#**_____

Employer's Name: _____

Employer's Address: _____

Primary Care Physician: _____ **Phone #:**_____

Primary Physician Address: _____

Would you like us to send medical records to this physician? [ ] Yes [ ] No

How did you hear about Ledesma Foot and Ankle?_____

Financial Information

[ ] Self Pay [ ] Insurance [ ] Medicare [ ] Worker's Comp [ ] Other

Primary Insurance Carrier:_____ **ID#:**_____

Group #:_____ **Phone #:**_____

Secondary Insurance Carrier:_____ **ID#:**_____

Group #:_____ **Phone #:**_____

<u>Authorization for Release of Medical Information:</u>

I hereby authorize Ledesma Foot & Ankle to furnish my medical records consisting of, but not limited to, consultation note, diagnostic test results, progress notes, operative reports and other medical information to the above stated physician. This release is in effect for one year from date noted.

_____ **Date:** _____

Signature of patient or patient's parent/ legal guardian

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Reason for Today's Visit

Have you seen Dr. Ledesma/Pirozzi/Doyle in the past? [ ] Yes [ ] No

Please describe the foot/ankle issue that brings you in today: [ ] Left [ ] Right_____

_____

Was this due to a work related injury or personal accident? [ ] Yes [ ] No **If yes, please list date of injury and nature of injury:** _____

Duration of problem?_____ **Have you had this problem in the past?** [ ] Yes [ ] No

How would you rate your pain on a scale of 0 (no pain)- 10 (worst pain)? _____

What treatment have you tried?_____

Does anything make it feel better or worse?_____

Past Medical History

Are you diabetic? [ ] Yes [ ] No If yes, how long_____ What type? _____

Do you have any of the following? [ ] No Past Medical History

[ ] High Blood Pressure [ ] High Cholesterol [ ] Cancer [ ] Heart Attack [ ] Stroke
[ ] Rheumatoid Arthritis [ ] Kidney Disease [ ] Heart Failure [ ] Stomach Bleeds
[ ] Blood Clots [ ] Other:_____

Past Surgical History

Please list any past surgical procedures you have had. [ ] No Past Surgical History

1._____**Year:**_____ **4.**_____**Year:**_____

2._____**Year:**_____ **5.**_____**Year:**_____

3._____**Year:**_____ **6.**_____**Year:**_____

Current Medication(s)

Please list any medications you are currently taking at this time. (including over the counter medications and supplements) [ ] No Current Medications

1._____**Dose:**_____ **4.**_____**Dose:**_____

2._____**Dose:**_____ **5.**_____**Dose:**_____

3._____**Dose:**_____ **6.**_____**Dose:**_____

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Allergies

Please list any allergies to medications, latex, or food: [ ] No Known Allergies

1._____**Reaction:**_____ **4.**_____**Reaction:**_____

2._____**Reaction:**_____ **5.**_____**Reaction:**_____

3._____**Reaction:**_____ **6.**_____**Reaction:**_____

Social History

Martial Status: [ ] single [ ] married [ ] divorced [ ] widowed [ ] separated

Current Employment Status:
[ ] Full-time [ ] Part-time [ ] Student [ ] Retired [ ] Disabled [ ] Unemployed

Occupation:_____

Do you smoke cigarettes?
[ ] Never [ ] Current Smoker, _____packs/day for _____ years [ ] Past Use, quit _____ years ago

Do you drink alcohol? [ ] Yes, how much? _____ [ ] No

Do you use illegal drugs? [ ] Yes, what and how much? _____ [ ] No

Family History

[ ] Diabetes; Relationship:_____[ ] Cancer; Relationship:_____
[ ] High Blood Pressure; Relationship:_____[ ] Stroke; Relationship:_____
[ ] High Cholesterol; Relationship:_____[ ] Other; Relationship:_____
[ ] Rheumatoid Arthritis; Relationship:_____ [ ] None or Unknown

Review of Systems

General: [ ] Loss of appetite [ ] Recent weight loss/ gain [ ] Fatigue [ ] Fever or chills [ ] Weakness
Respiratory: [ ] Shortness of breath [ ] Cough [ ] Coughing blood [ ] Difficulty breathing [ ] Wheezing
Cardiovascular: [ ] Chest pain [ ] Tightness [ ] Palpitations [ ] Swelling [ ] Difficulty breathing lying
Head/ Eyes/ Ears/ Nose/ Throat
[ ] Headache [ ] Neck Pain [ ]Decreased Hearing [ ]Ringing in ears [ ]Vision loss/ changes [ ]Glaucoma
[ ]Cataracts [ ]Blurry/ double vision [ ] Itching nose [ ]Sinus pain [ ]Nosebleeds [ ] Dentures
[ ] Mouth Sores/ bleeding [ ] Sore Throat [ ] Dry mouth
Neurological: [ ] Dizziness [ ] Fainting [ ] Seizures [ ] Numbness [ ] Tingling
Gastrointestinal: [ ] Nausea [ ] Vomiting [ ]Constipation [ ]Diarrhea [ ] Difficulty swallowing [ ]Heartburn
Endocrine: [ ]Sweating [ ] Frequent Urination [ ] Excessive thirst [ ] Change in appetite
Psychiatric: [ ] Nervousness [ ] Stress [ ] Depression [ ] Memory loss
Skin: [ ] Rashes [ ] Itching [ ] Dryness [ ]Hair or Nail Changes [ ] Skin color changes
Kidney/ Bladder/ Urine: [ ] Freqyency [ ] Urgency [ ] Burning or pain [ ]Blood in urine [ ] Incontinence
Musculoskeletal: [ ] Muscle or joint pain [ ] stiffness [ ] back pain [ ]swelling of joints

_____ **Date:** _____
Signature of patient or patient's parent/ legal guardian