NFAC-Holland
388 Garden Ave, Suite 120
Holland, MI 49424
P: 616-393-8886
F: 616-393-9975

Northwood
Foot and Ankle Center, P.C.
www.northwoodfootandankle.com

NFAC-St. Joseph
1901 Niles Ave, Suite 201
St. Joseph, MI 49085
P: 269-429-7670
F: 269-429-9981

PATIENT INFORMATION

(Please print with ink pen)

Full Legal Name: _____ Date of Birth: _____

Address: _____ City: _____Zip: _____

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

Employer Name_____ Occupation_____

Email Address: _____

(by providing this email you are confirming this is a private address or one with which you are comfortable receiving direct information from us)

Gender: Male Female Marital Status: Single Married Widowed

Primary Doctor: _____ Other Physicians: _____

Preferred Pharmacy & Location: _____

Referred By: Primary Doctor Family member Friend Other_____

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Please provide the following information on the patient:

Race: Black/ African American White/Caucasian Other_____

What is the patient's first language? English Other _____ I choose not to report this information

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EMERGENCY CONTACT INFORMATION

(Please List 2 Emergency Contacts)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____DOB:_____

☐ I authorize the above person to have access to my healthcare information.

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____DOB:_____

☐ I authorize the above person to have access to my healthcare information.

PERSON RESPONSIBLE FOR BILL

Full Legal Name: _____Relationship: _____

Address: _____ Home Phone: _____

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INSURANCE, MEDICARE, WORKER'S COMPENSATION, OR WELFARE INFORMATION

Company Group Number Policy Holder Policy holder's date of birth

1._____

2._____

Is this visit Auto or Worker's Compensation Related? Yes No If yes, date of Injury: _____

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MEDICAL INFORMATION
(THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH)

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Date you last saw this Doctor: _____

Do you have Diabetes? Yes No Year Diagnosed: _____ If yes, do you take insulin? Yes No

Are you allergic to any medication or substances? Yes No If yes, please list: _____

_____

List serious illnesses: _____

List previous surgeries: _____

_____

List the medications & dosages you take regularly including vitamins or supplements (use attached sheet)

Are you or could you be pregnant? Yes No Due Date: _____

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Review of Systems:
Please indicate any symptoms you have experienced in the last 12 months:

CARDIOVASCULAR:	MUSCULOSKELETAL:	NEUROLOGICAL:	PERIPHERAL VASCULAR:
Chest Pain	Joint Stiffness	Numbness	Swollen Legs
Shortness of Breath	Foot Pain	Tingling	Temperature Changes of feet
	Joint Aches/Pains	Burning	Easy Bruising
	Lower Extremity Weakness	Frequent Stumbling/Falling/Dizziness	

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Past Medical History:
Have you ever been treated or been informed by a physician that you have had any problems with the following?

Anemia	Circulatory Problems	HIV / AIDS	Sleep Apnea
Arthritis	Diabetes	Intestinal Problems	Stomach Ulcers
Asthma	Drug Abuse	Kidney Disease	Stroke
Bleeding Disorder	Gout	Liver Disease	Tuberculosis
Blood Clots	Healing Problems	Lung Disease	
Blood Pressure Problems	Heart	Neurological Disorder	
Cancer	Hepatitis	Sickle Cell Disease	

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Social History:
Do you smoke? Yes No Number of packs per day: _____ Start Date? _____

Have you smoked previously? Yes No Number of years: _____ End date: _____

Do you drink alcohol? Yes No ____ Light usage (1-2 weekly) ____ Moderate usage (3-4weekly) ____ Heavy usage (daily)

Do you use Recreational Drugs? Yes No Number of years: _____ End date: _____

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Family History:

	Living	Deceased	Bleeding disorder	Blood Clots	Cancer	Diabetes	Heart Disease	Hypertension	No known/ Unknown
Father									
Mother									
Brother(s)									
Sister(s)									

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GENERAL INFORMATION

Patient Name: _____ Date of Birth: _____

Height: _____Weight: _____ What is your Shoe Size? _____

Referral source: Primary Doctor: _____ Other: _____

What specific problem brings you to our office today? _____

_____

_____

Describe the type of pain you are experiencing (mark all that apply):

Aching Pain	Itching	Shooting Pain	Tingling
Burning Pain	Numbness	Tenderness	Other_____
Dull Pain	Sharp Pain	Throbbing Pain	_____

When did your symptoms start? _____

What makes your pain or problem better?

Walking and/or Running	High Heels	Flat Shoes	Any Closed Toe Shoe
Resting	Standing	Daily Activities	Ice
Stretching	Other _____		

What makes your symptoms worse?

Rest	At the end of the day	During Activity	
After Activity	Stretching	Shoe gear	Ice
Other_____			

When are your symptoms most bothersome?

First thing in morning At end of day Throughout the day During activity After activity

Have you had any previous treatment or have you tried any home remedies for this problem? _____

_____

_____

How would you rate your pain on a scale from 0 to 10?

[no pain] 0 1 2 3 4 5 6 7 8 9 10 [worst pain possible]

Please list physical activities in which you are involved (including what your job entails): _____

_____

_____

Other information you would like the Doctor to know about:

_____

_____

I certify that the above information is true and current to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

PATIENT SIGNATURE/GUARDIAN: _____ DATE: _____

PRINT PARENT/GUARDIAN NAME: _____

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Patient Name: _____ Date of Birth: _____ Date: _____

** Please list all medications including over the counter medications and supplements.

Medication Name	Dosage (mg)	Frequency	Reason for taking	Who Prescribed it