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[www.northwoodfootandankle.com](http://www.northwoodfootandankle.com)

NFAC-St. Joseph  
1901 Niles Ave, Suite 201  
St. Joseph, MI 49085  
P: 269-429-7670  
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**PATIENT INFORMATION**

Full legal name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 (By providing this email you are confirming that this is a private address or one with which you are comfortable receiving direct information from us.)  
 Home phone: \_\_\_\_\_  Preferred Cell phone: \_\_\_\_\_  Preferred  
 Employer name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Work phone: \_\_\_\_\_  
 Gender:  Male  Female Marital status:  Single  Married  Widowed  
 How did you hear about us? (circle) Physician Google Family Patient Friend Other: \_\_\_\_\_  
 Primary care physician's name: \_\_\_\_\_ Other physicians: \_\_\_\_\_  
 Were you referred by primary care physician?  No  Yes

**POWER OF ATTORNEY**

Do you have a Power of Attorney for health care?  No  Yes Name of designated individual: \_\_\_\_\_  
 Your P.O.A.'s phone number: \_\_\_\_\_ Please bring a copy of the documentation with you to your appointment.

**EMERGENCY CONTACT INFORMATION**

*Please list 2 contacts.*

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home/cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 I also authorize the above person to have access to my healthcare information *(must provide date of birth.)*  
 2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home/cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 I also authorize the above person to have access to my healthcare information *(must provide date of birth.)*

**PERSON RESPONSIBLE FOR BILL**

Full legal name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE, MEDICARE, WORKERS' COMPENSATION INFORMATION**

Insurance company	Policy holder's name	Policy holder's date of birth
1) _____	_____	_____
2) _____	_____	_____

Is this visit Auto or Workers' Compensation related?  No  Yes If yes, date of injury: \_\_\_\_\_

**MEDICAL INFORMATION**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Date you last saw this physician? \_\_\_\_\_

Are you allergic to any medication or substance?  No  Yes If yes, please list: \_\_\_\_\_

**REVIEW OF SYSTEMS**

*Please CIRCLE any symptoms you are CURRENTLY experiencing*

CARDIOVASCULAR

MUSCULOSKELETAL

NEUROLOGICAL

PERIPHERAL VASCULAR

Chest pain

Joint stiffness

Numbness

Swollen legs

Shortness of breath

Foot pain

Tingling

Temperature changes of feet

Joint aches or pains

Burning

Easy bruising

Lower extremity weakness

Frequent stumbling or falling

**MEDICAL HISTORY**

Anemia

Circulatory problems

High cholesterol

Neurological disorder

Arthritis

Dementia

HIV and/or AIDS

Sickle Cell Anemia

Asthma

Drug or alcohol abuse

Intestinal problems

Sleep apnea

Bleeding disorder

Gout

Kidney problems

Stomach ulcers

Blood clots

Healing problems

Liver disease

Stroke

Blood pressure problems

Heart problems

Lung disease

Thyroid

Cancer: \_\_\_\_\_

Hepatitis A, B, or C

Mental illness: \_\_\_\_\_

Other: \_\_\_\_\_

Are you Diabetic?  No  Yes Type 1 or Type 2: \_\_\_\_\_ Year diagnosed: \_\_\_\_\_

Are you, or could you be pregnant?  No  Yes Due date: \_\_\_\_\_

List any serious illness or hospitalizations: \_\_\_\_\_

**SURGICAL HISTORY**

Please list all surgeries, include year: \_\_\_\_\_

**SOCIAL HISTORY**

Tobacco use:  Current  Former (Year quit: \_\_\_\_\_)  Never  E-Cigs  Other: \_\_\_\_\_

Alcohol use:  No  Yes  Light usage (1-2 weekly)  Moderate usage (3-4 weekly)  Heavy usage (daily)

Recreational drug use:  No  Yes What type, please list: \_\_\_\_\_

**FAMILY HISTORY**

	Living	Deceased	Bleeding disorder	Blood clots	Cancer	Diabetes	Heart disease	Hypertension	No known/ unknown
Father									
Mother									
Brother(s)									
Sister(s)									



