Northwood
Foot and Ankle Center, P.C.

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

Full legal name: _____ Preferred 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: _____ Work phone: _____

Occupation:_____

Gender: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Widowed

How did you hear about us? *(circle one)* Physician Google Family Patient Friend Other:_____

Primary care provider's name: _____ Other physicians: _____

Were you referred by primary care provider? ☐ No ☐ Yes Pharmacy: _____

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: _____

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MEDICAL INFORMATION

Patient name: _____ Date of birth: _____

Primary care provider: _____ Date you last saw this provider?_____

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	Unknown
Father									
Mother									
Brother(s)									
Sister(s)									

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Patient name:_____ **Date of Birth:**_____ **Date:** _____

Please list **ALL** medications, including over-the-counter medications and supplements.

Medication/Supplement name	Dosage (mg)	Frequency	Form (Tablet, Capsule, etc.)	Reason for taking	Prescriber (Physician)

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CURRENT FOOT AND ANKLE PROBLEM(S)

Patient name: _____ Date of birth: _____

Height: _____ Weight: _____ Shoe size: _____

1. Main reason for your appointment today: _____

_____

_____

2. When did your symptoms start? _____

3. Describe the TYPE of symptoms you are experiencing (circle all that apply).

Aching pain	Sharp pain	Numbness	Itching
Burning pain	Shooting pain	Tenderness	Other: _____
Dull pain	Throbbing pain	Tingling	

4. What makes your symptoms BETTER? (circle all that apply)

Walking and/or running	Stretching	Flat shoes	Ice
Sitting	Exercise	Closed toed shoes	Heat
Standing	Daily activities	High heels	Other: _____

5. What makes your symptoms WORSE? (circle all that apply)

Rest	Running	Shoe gear	Heat
Standing	Walking	Ice	Other: _____

6. When are your symptoms most bothersome? (circle all that apply)

First thing in the morning | Throughout the day | End of the day | During activity | After activity

7. Have you had any previous treatment or have you tried any home remedies for this problem (specify)? _____

_____

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

0 1 2 3 4 5 6 7 8 9 10

[0 = no pain] [10 = worst pain possible]

9. Please list all physical activities in which you are involved (include sports/exercise and work activities - i.e. standing, walking, bending):

_____

_____

10. Other information you would like the physician 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) Date

_____

Patient name (PRINT)

_____ _____

Guardian/Representative (SIGNATURE) Date

_____

Guardian/Representative name (PRINT)