ALOHA FOOT AND ANKLE ASSOCIATES, INC

Last Name ______________________________First Name______________________ Middle Initial _______Sex ☐ M ☐ F
Address _____________________________________ City _________________________________ State_______ Zip_________
Cell phone (___) _________________ Home Phone (___)_______________ Work (___)__________________
Social Security #____/____/_____ Race _______________Ethnicity ______________Date of Birth___/___/___
Marital status ___________________________________ Children # _________________ Ages_________________________
Employer _________________________ City _________________________________ State _____________Zip___________
Occupation _____________________May we call you at work ☐ Y ☐ N Work hours______________________________

Spouse/Domestic Partner Information (If appropriate)

Last Name: ________________________ First Name ____________________ Middle Initial ___________Sex ☐M ☐F
Social Security #____/____/_____ Date of Birth ___________________ Phone (___) ________________ Ext _____

Please select your preferred contact method for outstanding balances:

☐ Email____☐Regular mail ☐Fax (____)__________________

Financially Responsible Party (If different from patient)

Last Name_____________________________ First Name______________________ E-mail___________________________
Address _____________________________________ City _________________________________ State_______ Zip_________
Date of Birth _____/_____/_______ Employer ___________________ Phone (___) _______________________Ext ____

Insurance Information (Please bring insurance card to each appointment)

Type of Insurance ☐ PPO ☐HMO ☐ POS ☐EPO ☐Medicare ☐Self Pay ☐Workers Comp
Does your insurance require prior authorization? ☐ Yes ☐No

<u>Primary Insurance</u> _________________________ Phone (___) ____________________ Group # ___________________
Address____________________________________ City __________________________ State________ Zip ________________
Insured's Last Name __________________________ First Name ________________________ ID# _____________________
Insured's D.O.B. _______________ Copay $ ______ (required at each visit) Coinsurance % ____________________
Deductible _________Amount Met _________ Limits ____

<u>Secondary Insurance</u> _________________________ Phone (___) ____________________ Group # ________________
Address____________________________________ City __________________________ State________ Zip ________________
Insured's Last Name __________________________ First Name ________________________ ID# _____________________
Insured's D.O.B. _______________ Copay $_______ Deductible _________Amount Met _________ Limits ________

Primary Care Physician ____Phone (___) ___________________________

Primary Pharmacy ____ Phone (___) ___________________________

In Case of Emergency

Who should we notified __________________ Relationship ______________________ Phone (___) ________________

<u>PLEASE BRING INSURANCE CARD AND A GOVERNMENT ID WE WILL MAKE COPIES FOR YOUR FILE</u>

Please read and sign below: I directly assign all medical and surgical benefits to Aloha Foot and Ankle. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize Aloha Foot and Ankle Associates to release all information necessary to secure the payment of benefits. I understand that fees for service and insurance copays are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than thirty (30) days for payment. After thirty (30) days you will be billed for any outstanding balance on your account. All outstanding balances are due upon receipt.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. ________________________________ Date______________________

ALOHA FOOT AND ANKLE ASSOCIATES, INC

Foot and Ankle Problem History Form: Please Print and Fill Out One Form of This Type for Each Unique Problem
This is my Foot or Ankle Problem Number: (Please Circle One) 1 2 3 4 5 6 7 8 9 10

Last Name ____________________ First Name______________ Middle Initial _______ Date ___________

Who referred you to Aloha Foot and Ankle? ____

PLEASE DESCRIBE YOUR PRIMARY FOOT/ANKLE CONDITION ☐ RIGHT ☐ LEFT ☐ BOTH (Please use appropriate level of detail)
____
____
____
____

DESCRIPTION OF ONSET (Check any and all that apply, detail is important!) When did this problem begin? Date ______________
☐ Congenital ☐ Crush ☐ Repetitive use ☐ Sudden onset ☐ Slip/Fall ☐ Sport related ☐ Twist ☐ Direct blow ☐ Gradual onset
☐ Other _ ____
Is this problem work related? ☐Yes ☐No * ***If Yes, please fill out Worker's Compensation History Forms and bring copies of all related medical history, any laboratory results ,imaging studies or other pertinent information with you.***

PAIN SCALE (Circle) ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
IS YOUR PAIN WORSE IN THE: Morning? ☐ Evening? ☐ All Day? ☐
QUALITY OF PAIN ☐ Sharp ☐ Dull ☐ Radiating ☐ Burning ☐ Aching ☐ Cramping ☐ Continuous ☐ Intermittent ☐ Other _______
WHAT IMPROVES YOUR PAIN? ____________________**WHAT WORSENS YOUR PAIN?** ____________________

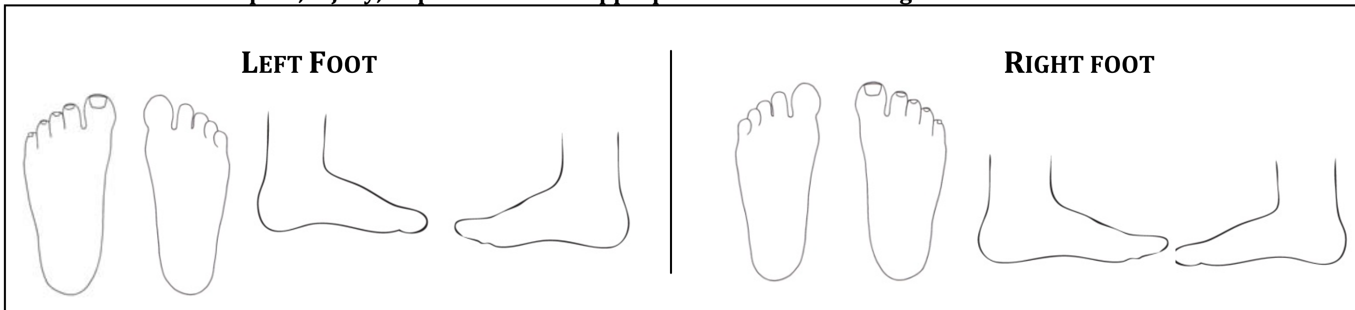
If you have had prior treatment, please bring all imaging films to your first appointment, and if you have a prior surgical failure, or post-traumatic deformity, please bring pertinent medical records such as surgical reports or discharge summaries from hospital admissions.

	Date Taken?				Date Taken?		
Previous X- rays?	__________	☐ Yes	☐ No	Previous MRI?	__________	☐ Yes	☐ No
Previous CT Scan?	__________	☐ Yes	☐ No	Previous Labs?	__________	☐ Yes	☐ No

PREVIOUS TREATMENT? (Including Self-Care & Surgery) ☐Yes ☐No If yes, check appropriate box below

☐ Steroid injection	How many? _____ Date of last injection ________	Helped?	☐ Yes	☐ No
☐ Anti-inflammatory pills	Name of medication ____________________	Helped?	☐ Yes	☐ No
☐ Pain Pills	Name of medication ____________________	Helped?	☐ Yes	☐ No
☐ Orthotics ☐OTC Inserts	Are you currently using them? ☐ Yes ☐ No	Helped?	☐ Yes	☐ No
☐ Cast or other Immobilization	How Long? ____________________	Helped?	☐ Yes	☐ No
☐ Surgery Date________	What Type? ____________________	Helped?	☐ Yes	☐ No
☐ Surgery Date________	What Type? ____________________	Helped?	☐ Yes	☐ No
☐ Surgery Date________	What Type? ____________________	Helped?	☐ Yes	☐ No
☐Other ______________	____________________	Helped?	☐ Yes	☐ No
☐Other ______________	____________________	Helped?	☐ Yes	☐ No
☐Other ______________	____________________	Helped?	☐ Yes	☐ No
☐Other ______________	____________________	Helped?	☐ Yes	☐ No

Please mark areas of pain, injury, or problem in the appropriate areas on the diagrams below.



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ALOHA FOOT & ANKLE ASSOCIATES, INC.

Patient Name: ________________________________
Date: _______________

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left ____

____

2. **Describe the pain/discomfort:** ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ______________________

3. **When did the pain/discomfort begin?** ____

4. **What makes the pain/discomfort better:** ____

5. **What makes the pain/discomfort worst:** ____

6. **List all medications/herbs/vitamins:** ☐ **NONE** ____

____

7. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _______________ ☐ Latex _______________ ☐ Narcotic Agent / Codeine _______________
☐ Anesthesia _______________ ☐ Shellfish _______________ ☐ Sulfa Drugs _______________
☐ Adhesive Tape ____________ ☐ Radiographic Contrast Dye ______________________________
☐ Other ____

8. **Past Medical and Family History**

Condition	Self	Family		Condition	Self	Family	
Anemia	☐	☐	____________	Mitral Valve Prolapse	☐	☐	____________
Anesthetic Reaction	☐	☐	____________	MRSA	☐	☐	____________
Arthritis	☐	☐	____________	Multiple Sclerosis	☐	☐	____________
Asthma	☐	☐	____________	Nails Disorders	☐	☐	____________
Bleeding Disorders	☐	☐	____________	Nerve Disorders	☐	☐	____________
Cancer	☐	☐	____________	Osteoporosis	☐	☐	____________
Circulation Problems	☐	☐	____________	Pacemaker	☐	☐	____________
Diabetes Avg Glucose____	☐	☐	____________	Phlebitis	☐	☐	____________
Foot Problem(s)	☐	☐	____________	Pulmonary Disease	☐	☐	____________
Gout	☐	☐	____________	Rheumatic Fever	☐	☐	____________
Heart Disease	☐	☐	____________	Skin Problems	☐	☐	____________
Hepatitis	☐	☐	____________	Sleep Apnea	☐	☐	____________
High Blood Pressure	☐	☐	____________	Stomach/Intest Problems	☐	☐	____________
HIV/AIDS	☐	☐	____________	Stroke	☐	☐	____________
Injury Trauma - Major	☐	☐	____________	Varicose Veins	☐	☐	____________
Kidney Disease	☐	☐	____________	Other: ____________________			
Liver Disease	☐	☐	____________	________________________			

9. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: ____

____

10. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits________________________________
☐ Caffeine Use ☐ Drug use (recreational, IV)

11. **Occupation:** ______________________ **Is your problem work related?** ☐ Yes ☐ No

12. **Are you currently pregnant?** ____

13. **Shoe Size:** __________ **Height:** __________ **Weight:** __________ **Blood Pressure:** __________

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional:	Y	N
Generally do you feel well?	☐	☐
Do you feel fatigued during the day?	☐	☐
Does your problem limit your normal daily activities?	☐	☐
Do you have a fever?	☐	☐

Eyes:	Y	N
Do you wear glasses or contacts?	☐	☐
Do you have burning or itchy eyes?	☐	☐
Do you have sensitivity to light?	☐	☐
Do you have watering of your eyes?	☐	☐
Are your eyes frequently red?	☐	☐
Do you have eye pain?	☐	☐

Ears, nose, mouth & throat:	Y	N
Do you have ringing in your ears?	☐	☐
Do you get nosebleeds?	☐	☐
Do you have difficulty swallowing?	☐	☐

Cardiovascular:	Y	N
Have you noticed your legs or ankles swelling?	☐	☐
Do you have varicose veins?	☐	☐
Do you have cramps in your legs at night or at rest?	☐	☐
Do you have cramps in your legs when walking?	☐	☐
Do your feet feel especially cold?	☐	☐

Respiratory:	Y	N
Do you have chest pain?	☐	☐
Do you have difficulty breathing?	☐	☐
Do you have shortness of breath?	☐	☐
Have you had a cough lasting longer than 3 weeks?	☐	☐

Gastrointestinal:	Y	N
Do you have a loss of increase in appetite?	☐	☐
Do you have a history of stomach ulcers?	☐	☐
Do you have heartburn?	☐	☐
Does Aspirin cause stomach pain?	☐	☐
Do you have bloody or dark stools?	☐	☐

Genitourinary:	Y	N
Do you urinate more frequently than before?	☐	☐
Do you have pain with urination?	☐	☐
Do you have burning with urination?	☐	☐
Have you noticed blood in your urine?	☐	☐

Musculoskeletal:	Y	N
Do you have low back pain?	☐	☐
Do you have pain in your legs?	☐	☐
Do you have foot pain?	☐	☐
Do you have joint pain?	☐	☐
Do you have bone pain?	☐	☐
Do you have general muscle aches or pains?	☐	☐
Have you had swelling in your legs?	☐	☐
Have you had joint swelling or stiffness?	☐	☐
Have you noticed a change in the way you walk?	☐	☐
Is it difficult to climb stairs?	☐	☐
Are you experiencing a loss of strength in your legs?	☐	☐
Have you felt rigidity in your legs?	☐	☐
Do you limp when you walk?	☐	☐
Do your shoes wear out quickly or unevenly?	☐	☐

Integumentary (Skin):	Y	N
Do you have any skin problems?	☐	☐
Is your skin strongly sensitive when exposed to the sun?	☐	☐
Do you have any skin rashes?	☐	☐
Do you have any warts on your feet?	☐	☐
Do you have any moles, lumps, bumps on your skin?	☐	☐
Do you have extremely dry skin or cracking?	☐	☐
Do you have any open skin sores?	☐	☐
Are there unusual areas of discoloration on your skin?	☐	☐
Do you have any corns or calluses on your feet?	☐	☐
Are your nails unusually thick?	☐	☐
Are your nails deformed?	☐	☐
Are your nails ingrown and tender?	☐	☐
Do your nails cause you pain?	☐	☐
Do you have problems with your fingernails?	☐	☐
Do you have noticeable hair loss on your legs or feet?	☐	☐

Neurological	Y	N
Do you ever feel dizzy?	☐	☐
Do you often feel confused or disoriented?	☐	☐
Do you have problems with your balance?	☐	☐
Do you have frequent or reoccurring headaches?	☐	☐
Do you have seizures?	☐	☐
Do you have tremors of your extremities?	☐	☐
Do your legs often feel like they “are going to sleep”?	☐	☐
Do you have numbness in your legs?	☐	☐
-a feeling of burning in your legs?	☐	☐
-cramps or pain in the legs with walking or exercise?	☐	☐
-leg pain that is worse at night or at rest?	☐	☐
-leg pain all the time?	☐	☐
-experience shooting pain down your legs?	☐	☐
-paralysis (complete loss of muscle strength) in legs?	☐	☐

Psychiatric:	Y	N
Do you have a history of psychiatric problems?	☐	☐
Are you subject to mood swings?	☐	☐
Are you under a lot of stress?	☐	☐

Endocrine:	Y	N
Do you urinate more frequently than before?	☐	☐
Are you excessively thirsty?	☐	☐
Do you have a history of bad breath?	☐	☐
Are you experiencing night sweats?	☐	☐
Do you have swollen glands?	☐	☐
Have you had a significant weight change recently?	☐	☐

Hematologic / Lymphatic	Y	N
Do you bruise easily?	☐	☐

Allergic / Immunologic:	Y	N
If you get cut, does it take a long time to heal?	☐	☐
Do you have allergic reactions to medication, foods dye?	☐	☐