Patient Intake Form

Please fill out this form to the best of your knowledge. Your answers help us plan and provide your care.

Personal Information

Street _____ City _____ State _____ Zip _____
Phone _____ Email _____
Primary Language _____
Occupation _____ Married_____ Single _____
Referring Physician _____ PCP _____
Pharmacy Location _____ Pharmacy Phone _____
Medical Insurance Carrier _____ ID _____
Secondary Insurance _____ ID _____
Workman's Comp (*include adjuster's information, claim number, and date of accident):*
_____
_____

Advance Directive	Yes	No
Do you have a power of attorney?		
Do you have a living will? Do not resuscitate?		

Current Prescriptions *(list all medications you are taking at present)*

Medication name	Dosage/ Route	How often
Example: Lasix	*20 mg, PO*	*Daily*

Any medication allergies? _____

Mental Health Screening

Over the last 2 weeks, how many days have you:	None	Several days	More than half the days	Most days
Had little interest or pleasure in doing things?				
Felt down, depressed or hopeless?				

Past Medical History (*check all that apply)*

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot *(DVT/PE)*
- ☐ Coronary artery disease (*Heart attack)*
- ☐ COPD/emphysema
- ☐ Cancer/History of cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes Type I/II
- ☐ GERD
- ☐ Hepatitis (type ____)
- ☐ Hypertension *(High blood pressure)*
- ☐ Hyperlipidemia (*High cholesterol)*
- ☐ Migraine
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Please list any other conditions not mentioned above: _____

_____

Social History	Yes/ How much or often	No
Do you smoke tobacco?		
Do you drink alcohol?		
Have you ever struggled with addiction? If yes, have you been sober?		

Past Surgical History *(check all procedures that apply)*

- ☐ Appendectomy
- ☐ Coronary artery bypass (*open heart)*
- ☐ Cholecystectomy (*removal of gallbladder)*
- ☐ Gastric bypass
- ☐ Hysterectomy (*removal of uterus)*
- ☐ Joint repair/replacement (*i.e hip, knee, shoulder)*
- ☐ Nephrectomy (*removal of kidney)*
- ☐ Spinal surgery
- ☐ Splenectomy (*removal of spleen)*

Please list any other procedures not mentioned above: _____

_____

_____

Family History (*please indicate first degree relatives only)*

- ☐ Anemia
- ☐ Asthma
- ☐ Blood clot *(DVT/PE)*
- ☐ Coronary artery disease (*Heart attack)*
- ☐ COPD/emphysema
- ☐ Cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Dementia
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypertension *(High blood pressure)*
- ☐ Hyperlipidemia (*High cholesterol)*
- ☐ Osteoporosis
- ☐ Seizure
- ☐ Skin condition
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Anything else you would like to share with the provider? _____

_____

_____

_____

_____

Preventive Care	Date	Result
Colonoscopy		
CT of the chest (*lung cancer screening)*		
Mammogram		
Pap smear		

Would you be interested in learning more about *(check all that apply)***:**

- ☐ Botox
- ☐ Foot and ankle care/ peripheral neuropathy
- ☐ IV therapy (fluid hydration, vitamin injection)
- ☐ Skin care products

How did you hear about us?

_____

Extended authorization:
I authorize Cutting Edge Foot and Ankle Clinic/ Music City Primary Care to furnish information to insurance carriers concerning my illness and treatments. I hereby assign Cutting Edge Foot and Ankle Clinic/Music City Primary Care all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for any payment if I have not fulfilled their requirements.

Signature _____ *Date* _____

Consent to treatment:
I offer voluntary consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary for Cutting Edge Foot and Ankle Clinic/Music City Primary Care.

Signature _____ *Date* _____

I acknowledge the receipt of HIPAA privacy policy:

Signature _____ *Date* _____