

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE

CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE _____ PACKS/DAY FOR _____ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____

CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____

ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE

STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS

OTHER _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

YOUR MEDICAL HISTORY

ALLERGIES: NONE KNOWN MEDICATIONS _____

ANESTHESIA _____ FOODS _____

TAPE LATEX SHELLFISH IODINE OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

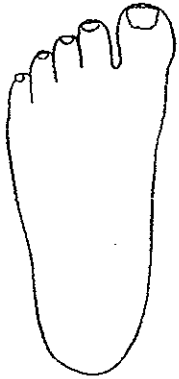
OTHER CONDITIONS: _____

CURRENT PROBLEM

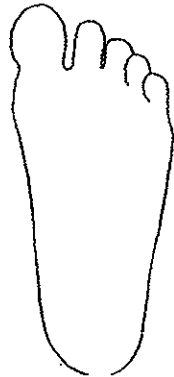
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT



BOTTOM OF FOOT

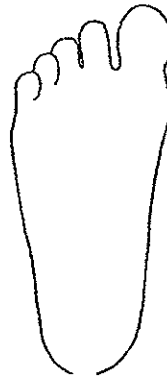


INSIDE OF FOOT

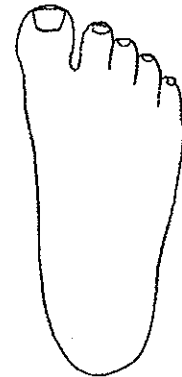


OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / ____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ NO

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

Electronic Prescription Consent

E-prescribing is defined by a Physician’s ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an e-prescribe program. Including:

- Formulary and benefit transactions – gives the physician information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications that patient is already taking to minimize the number of adverse drug events.

I authorize Martin J. Carey, DPM to view my external prescription history via e-prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies, and pharmacy benefit managers may be viewable by my provider and staff and may include prescriptions back in time for several years. I understand that my prescription history will become a part of my medical record.

I Accept

I Decline

Assignment and Release

I hereby authorize the processing of medical insurance wither by electronic or manual method by Martin J. Carey, DPM. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from my insurer to Martin J. Carey, DPM. I further authorize Martin J. Carey, DPM to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient or Guardian

Date

Record Release Authorization

I hereby authorize you to release a copy my medical records/information to:

Martin J Carey, DPM

2089 Route 9 North
Cape May Court House, NJ 08210
609.624.0123 phone --- 609.624.0034 fax

I understand that I have a right to revoke this authorization at any time and must do so in writing. Revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary and can refuse to sign this authorization. I need not sign this form in order to insure treatment. I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality and privacy regulations.

Patient or Guardian's Signature

Date