# Central Arkansas Foot Care

DIVISION OF JOSEPH M. LACAVA DPM, PA

Hot Springs: 501-321-4844

## PATIENT INFORMATION FORM

(Please Print Clearly)

Date: _______________

Patient Name: ______________________________Date Of Birth: _____________ Age: __Sex: M F

Address: ___________________________________City/State: __________________ Zip: _________

Home Phone: (____) ______- _____________ Cell Phone: (___) ____-_____________

Email Address: __________________________________ (WILL NEVER BE SHARED)
What Is The Best Way To Contact You? Home Cell Work Email

Employer: ______________________________________Work Phone: (___) ____-___________

Emergency Contact: _______________ Relationship: _______________ Phone: (___) _____- ________

Primary Care Doctor: _______________________________ Date Last Seen: ________________________

Phone: (____) ______- ________ Address: ____________________________ City/State: ______________

Pharmacy: _________________ Location: ________________________ Phone: (____) ______- ________

Who Is Responsible For Payment? ______________________________ Relationship: ________________

Address: ____________________________City/State: ______________Phone :(____) ______-_______

Who Referred You To Us?
__________________________________________________________________

**<u>Insurance Information</u>** **( ) see copy**
Primary Insurance Company Name: ___________________________ Phone: (____) ______- _________

Address: _________________________________City/State: __________________ Zip: _______________

Insured Name: ____________________________ Date of Birth: ________Employer: _________________

ID# _____________________________________Group#__________________________________________

Secondary Insurance Company Name: ___________________________ Phone: (____) ____- _________

Address: _________________________________City/State: __________________ Zip: _______________

Insured Name: ____________________________ Date of Birth: ________Employer: _________________

ID# _____________________________________Group#__________________________________________

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Patient Name_________________________________ Date of Birth_____________________

**MEDICATIONS**

Please list all medications you are currently taking (include prescriptions, over-the –counter meds and herbal supplements)

**Medication Name** **Dose** **How often do you take?**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**( ) see attached list**

PLEASE LIST ALL PRIOR SURGERIES:

Type of Surgery Date Type of Surgery 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 Products: ( )Never ( )Quit- How long ago?________

Type of tobacco product: _____________________________ Smoke ___packs/day for ___ years

Use of Recreational Drugs: ( ) Never ( ) Current Use- Type _____________________________________

( )Rare ( )Occasional ( )Moderate ( ) Daily

**FAMILY HISTORY** (circle M: mother, F: father)

Diabetes Type 1 or 2 M F Cancer: M F Heart Disease: M F High Blood Pressure: M F

Stroke: M F Coronary Artery Disease: M F Bleeding Disorder: M F

Rheumatoid Arthritis: M F Alcohol /Drug Abuse: M F

**Your Medical History**

Allergies: ( ) Medications: ___________________________________________________________

( ) Anesthesia: ___________________________ ( ) Foods: _________________________

( ) Tape ( ) Latex ( ) Shellfish ( ) Iodine ( ) Other: _________________________________

( ) None Known

Reaction: ______________________________________________________________________________

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Patient Name___________________________________ Date of Birth______________________

**Review Of Systems** circle (N) no or (Y) yes

**GENERAL, CONSTITUTIONAL**

Recent weight loss N Y
Fever N Y
Chills N Y

**EYES, VISION**

Visual change N Y

**EARS, NOSE, THROAT**

Hearing loss N Y
Post Nasal Drip N Y

**HEART CARDIOVASCULAR**

Chest pain or pressure N Y
Arrhythmia or palpations N Y
Peripheral Edema N Y
Blood Clots N Y
Varicose Veins N Y
Cramping in legs N Y

**RESPIRATORY**

Cough N Y
Shortness of breath N Y
Wheezing N Y
Sleep Apnea N Y

**GASTROINTESTINAL**

Abdominal pain N Y
Heartburn N Y
Bloody Stool N Y
Ulcer history N Y

**GENITOURINARY**

Frequent urination N Y
Urgency N Y

**MUSCULOSKELETAL**

Joint pain or swelling N Y
Restricted motion N Y
Musculoskeletal pain N Y

**SKIN**

Rashes N Y
Sores/Ulcers N Y
Blisters N Y
Growths N Y

**NEUROLOGICAL**

Numbness/Tingling N Y
Sensation loss N Y
Burning N Y
Balance difficulties N Y

**PSYCHIATRIC**

Nervousness/Anxiety N Y
Depression N Y
Alcohol/Substance Abuse N Y
Known mental health disorder N Y _________________________

**ENDOCRINE**

Heat/Cold intolerance N Y
Excessive thirst N Y
Excessive urination N Y

**HEMATOLOGICAL/LYMPATHIC**

Abnormal bleeding N Y
Lymph edema N Y

**ALLERGY/IMMUNOLOGICAL**

Allergic Reactions N Y
Recurrent infections N Y
Immunological infectious disease N Y
Other N Y ___________________________________

**Current Height: _________________ Weight: ______________ Shoe Size: ___________Width: _______**

Patient Name_________________________________ Date of Birth_____________________

**Your Medical History Continued**

**PMH**

Have You Ever Had Any Of The Following?

| Condition | | Condition | |
|---|---|---|---|
| Acid Reflux | N Y | Kidney Disease | N Y |
| Anemia | N Y | Liver Disease | N Y |
| Arthritis | N Y | Low Blood pressure | N Y |
| Asthma | N Y | Migraine headache | N Y |
| Back trouble | N Y | Mitral valve prolapse | N Y |
| Bladder infections | N Y | Neuropathy | N Y |
| Abnormal Bleeding | N Y | Open sores(ulcers) | N Y |
| Blood clots | N Y | Pneumonia | N Y |
| Blood transfusion | N Y | Polio | N Y |
| Bronchitis/Emphysema | N Y | Rheumatic fever | N Y |
| Cancer | N Y | Sickle Cell Disease | N Y |
| Diabetes: Type I or Type 2(circle) | N Y | Skin Disorders | N Y |
| | | Sleep Apnea | N Y |
| Fibromyalgia | N Y | Stomach Ulcers | N Y |
| Gout | N Y | Stroke | N Y |
| Heart Attack | N Y | Thyroid Disease | N Y |
| Heart Disease/Failure | N Y | Tuberculosis | N Y |
| Hepatitis | N Y | | |
| HIV+/AIDS | N Y | | |
| High Blood Pressure | N Y | | |

Other Conditions: ___________________________________
___________________________________

**CURRENT PROBLEM**

What specific problem brings you to our office today?
_________________________________________________________________________________________
_________________________________________________________________________________________

How long ago did it start? ___________Days/Weeks/Months/Years

Did you pain or problem: ( ) Begin all of a sudden ( )Gradually develop over time

How would you describe your pain or symptom?

( ) No pain ( ) Sharp ( )Dull ( )Achy ( )Burning ( )Radiating ( )Itching ( )Stabbing

( ) Other_________________________________________________________________________________

Since the time your pain began, has it: ( )Stay the same ( )Become worse ( ) Improved

What makes the pain or problem worse? ( ) Walking ( )Standing ( ) Daily activities ( )Resting ( )Dress shoes ( )High Heels ( ) Flat shoes ( )Any closed tope shoe ( )Running ( )Other_____________________

What make your pain or problems feel better? _________________________________________________

What treatments have you had for this problem? ______________________________________________

Was this problem caused by injury? ( )Yes ( ) No (Describe) _____________________________________

If Yes, was it a work –related injury? ( ) Yes ( )No

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Patient Name_________________________________ Date of Birth_____________________

**Demographic Required of Governmental Statistical Analysis collection of this information is mandatory, practice will be fined if not collected**

**Race**: ( ) American Indian or Alaska Native ( ) Asian ( ) Native Hawaiian ( ) Black or African American
( ) White ( ) Hispanic ( ) Non- Hispanic ( ) Other Pacific Islander ( ) Other Race
( ) I Decline to Report

**Ethnicity:** ( ) Hispanic ( ) Non- Hispanic ( ) I decline to report

**Preferred Language**: ( ) English ( ) Spanish ( ) Other

**Do you have an Advanced Care Plan (Living Will)?** Yes No (if you are 65 yo or older)
**Have you had a Pneumonia Shot**? Yes No (if you are 65 yo or older)

**Have you had a Flu (Influenza) Shot**? Yes No

I certify, to the best of my knowledge, I have answered all 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 and all changes in my medical status.

I give permission to the doctor at Central Arkansas Foot Care, A division of Joseph M. LaCava DPM, PA, to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patient/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, care taker or friend,over the age of 18 will be present; written consent form the parent or legal guardian stating as such must be presented at the time of the appointment. Thank you.
Patient Name: ________________________________________________ (Print)
Patient /Guardian Signature:__________________________________ Date: _____________________
Relation to signature: ( ) Self ( ) Parent/Guardian

HISTORY REVIEWED BY: JOSEPH M LACAVA DPM
Signature: __________________________________________ Date __________________