PREMIER
FOOT & ANKLE

Dr. Stefano Militello, Dr. Anthony LaLama, Dr. Jeri Berkowitz and staff would like to welcome you to the office.

Name: _____ **Date of Birth:** _____

Sex:____**Single:**____**Married:**____**Other**_____**Social Security No.:** _____

Address:_____**City:**_____**ZipCode:**_____

Home Phone:_____ **Cell Phone:** _____

Work Phone:_____**Employer:**_____

Pharmacy Information:_____**Phone:**_____

Primary Care Physician:_____**Phone:**_____

Who Referred you to the office: _____

What is you chief foot concern:_____

Who should we contact in case of an EMERGENCY:_____

Address for emergency contact:_____

Phone:_____

Primary Insurance:_____**Secondary Insurance:**_____

Insurance Subscriber: _____ **Date of Birth:**_____

I HEREBY GIVE PERMISSION TO THE DOCTORS OF PREMIER FOOT & ANKLE TO ADMINISTER TREATMENT AND TO PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY, INCLUDING PHOTOGRAPHS, I THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS AS REQUIRED BY MY HEALTH PLAN AND TO PAY THE ABOVE DOCTORS DIRECTLY.

Signature:_____**Date:**_____

By Signing below I acknowledge that I was provided and read (or had an opportunity to read if I so choose) and understand the Notice of privacy practices.

_____ _____

Name Date

_____ _____

Signature Parent or Authorized Representative

PREMIER FOOT & ANKLE

HEALTH HISTORY FORM

PATIENT NAME:_____ **AGE:**_____

EMAIL ADDRESS:_____

PLEASE INDICATE BY CIRCLING YES OR NO FOR CONDITIONS PAST AND PRESENT:

ALLERGIES OR HIVES	YES NO	ANEMIA	YES NO	ANGINA	YES NO
ARTHRITIS	YES NO	ARTIFICIAL HEART VALVE	YES NO	ARTIFICIAL JOINTS	YES NO
ASTHMA	YES NO	BLEEDING DISORDER	YES NO	BLOOD DISORDERS	YES NO
CANCER	YES NO	COPD	YES NO	DIABETES	YES NO
EMPHYSEMA	YES NO	EPILEPSY	YES NO	GOUT	YES NO
HEART ATTACK/DISEASE	YES NO	PACEMAKER	YES NO	HEART SURGERY	YES NO
HEPATITIS	YES NO	HIGH BLOOD PRESSURE	YES NO	HIGH CHOLESTEROL	YES NO
HIV/AID	YES NO	KIDNEY DISEASE	YES NO	ULCERS	YES NO
LIVER DISEASE	YES NO	MUSCLE PROBLEMS	YES NO	PHLEBITIS	YES NO
EARS, NOSE, THROAT	YES NO	PSYCHIATRIC TREATMENT	YES NO	RHEUMATIC FEVER	YES NO
SKIN DISEASE	YES NO	STENT IN HEART	YES NO	STOMACH ULCER	YES NO
STROKE	YES NO	TUBERCULOSIS	YES NO	URINARY PROBLEMS	YES NO

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICATION: DOSE: TIMES PER DAY:

_____

_____

_____

ALLERGIES AND REACTIONS:

_____

_____

HEIGHT: _____ **WEIGHT:**_____ **SHOE SIZE:**_____ **A 1 C:**_____

ARE YOU PREGNANT? YES NO

DO YOU SMOKE?: YES NO NEVER DAILY_____ OCCASIONAL_____ PACKS PER DAY_____

DO YOU DRINK ALCOHOL?: YES NO NEVER 1-2 WEEK_____ 1-2 DAY_____ SOCIAL_____

DO YOU HAVE A FAMILY HISTORY OF: HEART DISEASE DIABETES HYPERTENSION CANCER

Major Surgeries and Hospitalizations: (please list date, type of surgery, and reason)

_____

_____

Review of Systems: (please circle all that apply)

General:	Weight Change	Generally Healthy	Change in Strength	Change in exercise ability
Head: :	Headaches	Vertigo	Head injury	
Neck:	Stiffness	Pain)	Tenderness	Masses
Chest:	Dyspnea	Wheezing	Hemoptysis	Cough
Cardiac:	Chest Pain	Palpitations	Syncope	Orthopnea
Abdomen::	Change in Appetite	Dysphagia	Abdominal Pain	Bowel Habit Changes
Musculoskeletal:	Pain in Muscles/ Joints	Limitation of Movement	Pain Walking	Decreased Range of Motion
Neurologic::	Paresthesias/ Numbness	Weakness	Tremor	Seizures
Psychiatric:	Depression	Changes in sleep	Changes in thought	Anxiety

[ ] Please check if all are negative

Please list any other problems or concerns you think the physician should be aware of:

_____

_____

_____

_____

I HAVE READ MY MEDICAL HISTORY DATED_____ AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS

Patient Signature_____Date_____

Physician Signature_____Date_____

DATE	CHANGES		PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	NONE [ ]	_____	Dr._____
_____	_____	NONE [ ]	_____	Dr._____
_____	_____	NONE [ ]	_____	Dr._____
_____	_____	NONE [ ]	_____	Dr._____