Reading Foot & Ankle Specialist, P.C

Bart Kellerman, DPM
Phone: 781-944-8341
Fax: 781-944-3021

Caroline Gauthier, DPM
161 Ash Street
Reading, MA 01867

PATIENT INFORMATION

Patient's Name_____ Home Phone_____
First MI Last Work Phone_____

Address_____ Cell Phone_____
Street City ZIP

Email Address_____

___ Married ___Single ___Divorced ___Separated ___Widowed

AGE_____ DATE OF BIRTH___/___/_____ Sex ___Male ___Female

Which PHARMACY do you use_____

Which is the best number to reach you (CHECK ONE) ___HOME ___WORK ___CELL

Primary Care Physician_____Date Last Seen___/___/_____

Employer_____Occupation_____

Employer's Address_____
Street City ZIP

Emergency Contact_____Relationship_____Phone_____

PRIMARY INSURED (CHECK ONE) (if self, do not complete the rest of this section)

_____SELF ____SPOUSE _____PARENT ____CHILD ____Other

NAME_____Home Phone_____
First MI Last Work Phone_____

Address_____ Cell Phone_____

DATE OF BIRTH___/___/_____ Sex ___Male ___Female

Employer_____Occupation_____

Employer's Address_____

INSURANCE Primary Insurance Co_____Phone_____

Policy Holder's Name_____POLICY#_____GROUP#_____

Secondary Insurance Company_____Phone_____

If other than self: Policy Holder's Name_____

POLICY#_____GROUP#_____Policy Holder's Date of Birth___/___/_____

MEDICAL QUESTIONNAIRE

Patient's Name_____ Today's Date___/___/____

First MI Last Shoe Size_____

Age_____ DOB___/___/____ Sex ____M ____F Height_____ Weight_____

REASON FOR TODAY'S VISIT?_____First Date of Onset_____

Did this injury occur at work? Yes No If yes, please describe how:_____

If yes, have you reported this injury to your employer?_____

Referring Doctor:_____Primary Care Physician_____

Have you sought previous treatment for this problem? Yes No

If yes, specify including at-home or professional treatments:_____

PAST MEDICAL HISTORY (please 'x' if you have had any of these in the past)

__Anemia	__Fracture History, please specify:	__Osteoporosis
__Arthritis	_____	__Peripheral Vascular Disease
__Autoimmune Disease	__Fungal Infections	__Psoriasis
__Bleeding Disorders	__Gout	__Rheumatic
__Breathing problems	__Heart Disease	__Sciatica/Back Problems
__Cancer, please specify:	__High Blood Pressure	__Seizure Disorder
_____	__High Cholesterol	__Skin Cancer
__Cellulitis	__ Gastrointestinal Reflux/Ulcers	__Stroke
__Congestive Heart Faliure	__Kidney Disease/Dialysis	__Thyroid Problems
__Deep Vein Thrombosis	__Liver Disease	__Varicose Veins
__Neuropathy	__Warts	__Blood Clots: __Legs __Lungs

__Diabetes: __Diet __Pill __Insulin

CURRENT MEDICATIONS ___None ___I take the following medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES ___No known allergies ___I have the following allergies

__Penicillin __Sulfa __Adhesive/ TAPE __Cortisone __Codeine __Asprin/NSAIDS

__Local anesthetics OTHER:_____

PRIOR SURGERIES (All, not just foot and ankle)

_____ _____

_____ _____

SOCIAL HISTORY

Do You Smoke? __No I have never smoked __Yes, I have smoked for __ years

__Not currently, I quit __ years ago

Do you drink alcohol? __Yes, everyday(5/7 days/week) __No/Rarely __Yes, occasionally/socially

Substance abuse: __Yes, I currently have a substance abuse problem Specify:_____

__No, I have never had a substance abuse problem ___Yes, I had a past problem

Do you exercise regularly? __Yes, I do the following regular exercise:_____

__No, I do not exercise regularly

ARE YOU DIABETIC? __No If yes, check one: ___Diet Controlled ___Pill Controlled ___Insulin

FAMILY HISTORY (Please specify if parents or siblings had any of the following conditions)

__Diabetes __Circulatory Problems __Heart Disease __Gout __Blood Clots

__Hypertension/High Blood Pressure __Other:_____

__Complications with anesthesia

REVIEW OF SYSTEMS (Please mark 'x' if you have any of these symptoms)

Cardiovascular

__Leg pain when walking __Heart attack
__Chest pain __Chest pressure/angina
__Leg swelling __Cold hands/feet
__Leg cramps __High blood pressure

Eyes, Ears, Mouth, Nose, Throat

__Dizziness __Glaucoma
__Hearing loss __Cataracts
__Vision problems

Gastrointestinal

__Abdominal pain __Indigestion
__Blood in stool __Vomiting
__Ulcers __Diarrhea
__Heartburn

Hematologic

__Sickle cell disease __Clotting disorder
__Anemia __Bleeding problems
__Use of blood thinners

Musculoskeletal

__Back pain __Joint swelling
__Muscle weakness __Sciatica
__Neck pain __Joint stiffness
__Joint pain __Joint instability
__Arthritis

General

__Nausea __Chills
__Fever __Weight gain/loss

Endocrine

__Diabetes __Thyroid problems

Genitourinary

__Currently pregnant __Kidney stones
__Kidney disease __Excessive urination
__Urinary tract infections

Integumentary

__Athlete's foot __Nail abnormalities
__Keloids __Itchiness
__Dry, scaly skin __Lower leg ulcer
__Rash

Neurological

__Tingling/numbness __Weakness
__Seizures __Tremors
__Paralysis

Respiratory

__Difficulty breathing __Snoring
__Coughing
__Shortness of breath
__Wheezing

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment at Caroline Gauthier, DPM I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

_____ _____

Patient/Parent/Guardian **Date**

AUTHORIZATION

Acknowledgement of receipt of Notice of Privacy Practices

__YES __NO I acknowledge that the office complies with the Notice of Privacy Practices (HIPAA) and I will be provided a copy if requested.

Benefits to physician

__YES __NO I hereby authorize payments directly to the physician of the surgical/medical benefits

__YES __NO I understand I am responsible for any portion of my bill not covered by my insurance

Release of Information

__YES __NO I hereby authorize release of information for insurance claim purposes

__YES __NO I authorize the automated review of medication history

__YES __NO I authorize the use of eLINC records sharing

Responsible Party's Signature_____

Print Responsible Party's Name_____