**Caneva Foot & Ankle Clinic, LTD Patient Information Form (Please Print)**

Patient Name:______________________ Date of Birth:____________ Age:________ Sex: M F
Home Address:______________________ City/State:____________ Zip:____________
Home Phone:________________ Cell Phone:____________ Email: ________________
May we leave a Message? Y N
Social Security # (Responsible Party if minor)________________________________
Emergency Contact:________________ Relationship____________ Phone#:__________
Primary Care Doctor______________________ Phone#:______________________
Pharmacy______________________ Phone#:______________________
Who referred you to us?______________________________________________
Is there a family member or other person you would like for us to share your medical information?
_____Yes Name(s)________________________________________
_____No
Who is responsible for payment?__________________ Relationship to Patient__________
Address:__________________ City/State________ Zip:________ Phone:__________
Patient's Employer:______________________ Occupation:______________________
Address:______________________ Employer Phone:______________________

**Insurance Information**

Primary
Insurance:______________________ Address/Phone______________________
ID #:______________________ Group #:______________________
Insured Name:________________ Date of Birth:____________ Employer:____________

Secondary Insurance:__________________ Address/Phone______________________
ID #:______________________ Group #:______________________
Insured Name:________________ Date of Birth____________ Employer:____________

I attest the above information is true and correct. I authorize the release of any medical information necessary to process insurance filing.
Signed______________________________________________ Date______________

I assign payment directly to Dr. Daryl S. Caneva of individual or group hospital benefits of office benefits herein specified and otherwise payable to me.
I understand I am financially responsible to Dr. Daryl S. Caneva of charges not covered by this assignment. I am aware that over the counter supplies are not covered by insurance and I am financially responsible for all supplies given to me.
I understand any services, visits or procedures not authorized by my insurance company are my financial responsibility. I understand it is my responsibility to obtain full plan benefits and to obtain authorization before services, visits or procedures are rendered.
Signed______________________________________________ Date______________

I acknowledge that I have had access or have been provided a copy of the Notice of Privacy Practices and I have read
(or had the opportunity to read if I so chose) and understood the Notice.
Signed______________________________________________ Date______________

Please list all medication you are currently taking (Include prescriptions, over the counter meds and herbal supplements)

Name Dose How Often? Name Dose How Often?

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

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 ___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 ___Quite-How long Ago? ________ Type________

____Current Use –Type: __Rare __Occasional __

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) _________ ___Elderly or Disable Family Member

___Other________________________________________

Exercise: __Never __Rare __Occasional __Weekly __Several times a week __Daily

Type of Exercise______________________________________________

**YOUR MEDICAL HISTORY**

Allergies: ___None Known __Medications______________________________________________

____Anesthesia______________________________Foods______________________________

____Tape ___Latex ____Shellfish ____Iodine ____Other______________________________

Height:____________________ Weight:____________________ Shoe Size:____________________

Please circle the following:

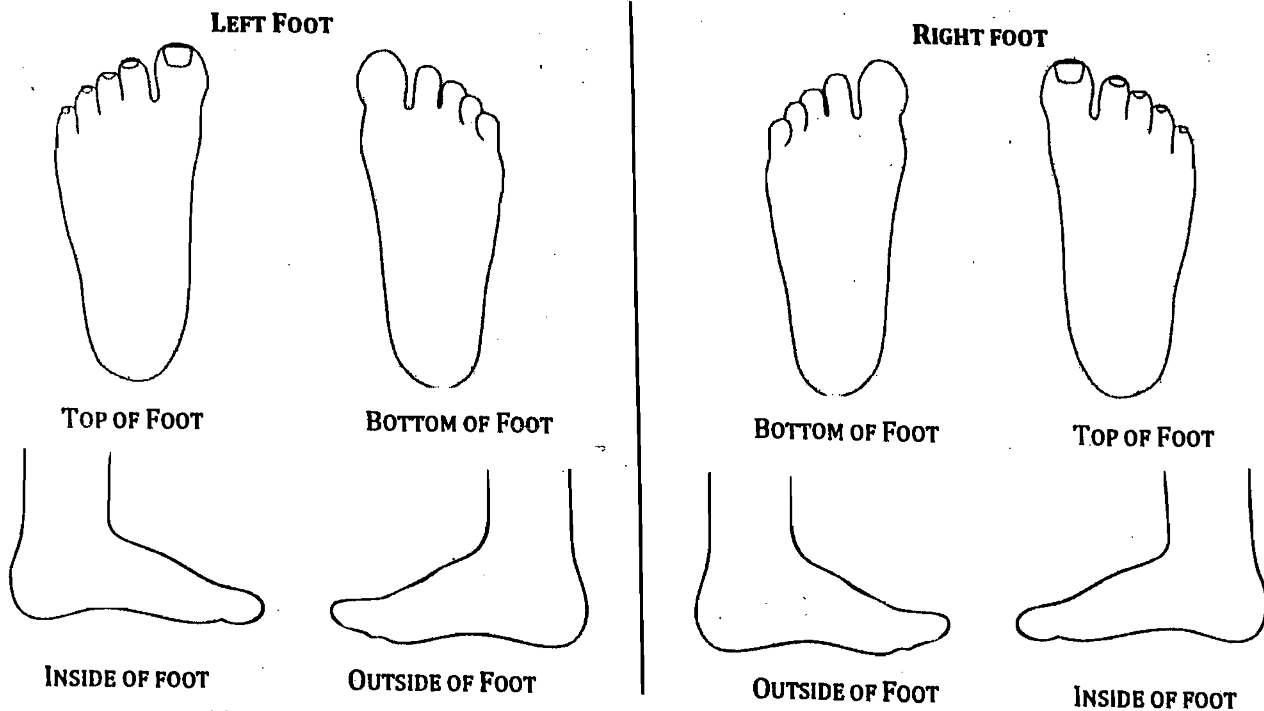
| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ACID REFLUX | CURRENT | PAST | NEVER | DIABETC NON-IDDM | CURRENT | PAST | NEVER | MRSA | CURRENT | PAST | NEVER |
| AIDS | CURRENT | PAST | NEVER | EMPHYSEMA | CURRENT | PAST | NEVER | NEUROPATHY | CURRENT | PAST | NEVER |
| ANEMIA | CURRENT | PAST | NEVER | FIBROMYALGIA | CURRENT | PAST | NEVER | OPEN SORES | CURRENT | PAST | NEVER |
| ARTHRITIS | CURRENT | PAST | NEVER | GOUT | CURRENT | PAST | NEVER | PNEUMONIA | CURRENT | PAST | NEVER |
| ASTHMA | CURRENT | PAST | NEVER | HEART ATTACK | CURRENT | PAST | NEVER | POLIO | CURRENT | PAST | NEVER |
| BACK TROUBLE | CURRENT | PAST | NEVER | HEART DISEASE | CURRENT | PAST | NEVER | PREGNANCY | CURRENT | PAST | NEVER |
| BLADDER INFECTION | CURRENT | PAST | NEVER | HEART FAILURE | CURRENT | PAST | NEVER | RHEUMATIC FEVER | CURRENT | PAST | NEVER |
| ABNORMAL BLEEDING | CURRENT | PAST | NEVER | HIV | CURRENT | PAST | NEVER | SICKLE CELL DIS. | CURRENT | PAST | NEVER |
| BLOOD CLOTS (DVT) | CURRENT | PAST | NEVER | HIGH BLOOD PRESSURE | CURRENT | PAST | NEVER | SKIN DISORDER | CURRENT | PAST | NEVER |
| BREAST FEEDING | CURRENT | PAST | NEVER | KIDNEY DISEASE | CURRENT | PAST | NEVER | SLEEP APNEA | CURRENT | PAST | NEVER |
| BRONCHITIS | CURRENT | PAST | NEVER | LIVER DISEASE | CURRENT | PAST | NEVER | STOMACH ULCER | CURRENT | PAST | NEVER |
| CANCER (OF ) | CURRENT | PAST | NEVER | LOW BLOOD PRESSURE | CURRENT | PAST | NEVER | STROKE | CURRENT | PAST | NEVER |
| DIABETIC IDDM | CURRENT | PAST | NEVER | MIGRAINE HEADACHES | CURRENT | PAST | NEVER | THYROID DISEASE | CURRENT | PAST | NEVER |

OTHER MEDICAL CONDITIONS:______________________________________________

**CURRENT PROBLEM**

What specific problem brings you to our office today?___________________________________________

Where is the pain/problem located? Please mark on the pictures below.




How long ago did this problem firs 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? __No ___Yes (Describe)____________________________

If yes, was it a work related injury? ___No ___Yes

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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.

Signature_______________________________________________Date ___________________

(Parent, if patient is a minor)