<u>Demographics/Insurance</u> (**All Information Given Here is Confidential**)

Name: ___________________________________ Age _____ Gender ______

Date of Birth: ___________ [] Single [] Married [] Widowed [] Divorced

Address: ____

City: ____________________________ State: ________ Zip: _________

Home Phone ________________ Cell Phone_______________________

E-mail:_____________________________

My preference for contact (Choose one) via [] Home Phone [] Cell Phone [] Work Phone

[ ] I give permission to leave Voice Mails regarding any medical tests on my
[ ]Home Phone Answering machine [ ] Cell Phone.

Ethnicity: Hispanic Non-Hispanic other [ ] Decline
Race: (Caucasian, African America) other_________________ [ ] Decline
What is your Foot Problem(brief)? ________________________________

Primary Care Physician/Pediatrician______________________________________

Work Location: ____

The Following people may Access my Chart

Name	**Relationship (spouse, child, other)**
______________________	_________________
______________________	_________________
______________________	_________________
______________________	_________________

Initial__________ Date_______________

>>>>>>>>> Continue on next Page <<<<<<<<<

Patient Medical History
Date:_________ Patient Name: ______________________ DOB ________

<u>Personal Habits:</u>
Current Smoker(circle one): Yes No Cigarettes/day____ #Years smoking___
Prev Smoker(circle one): **Yes No #Years smoking________**

Any Other Forms of Tobacco usage? Vaping?______ Years usage_______
Smokeless Tobacco/Chew? Currently using?____Years usage/used_______
Alcohol use: (circle one) None Occasional Moderate Heavy

Caffeine: None Occasional Moderate Heavy

Illicit Drug use: ____

Have you ever ABUSED any OTC or Prescription Drugs? [ ] Yes [ ] No
Medication name__________________________

*****DIABETICS ONLY*****
When was your last **Diabetic** Eye Exam? ___________By Whom?___________
When was your last Diabetic A1c performed? ___________

Medications (Dosage, How Often) Prescription and OTC			**Allergies** [ ] No Known Drug Allergies	**Reaction**
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________
_____________	____	_________	____________	_____________

- [] Additional Meds, Use the back page *

OFFICE USE ONLY

Height	Weight	Blood Pressure	Pulse	Temperature

Past Illnesses:

Alcoholism	Myself	Other____________	Lung Disease	Myself	Other____________
Anemia	Myself	Other____________	Mental Illness	Myself	Other____________
Asthma	Myself	Other____________	Muscular Sclerosis	Myself	Other____________
Cancer/Tumor	Myself	Other____________	Osteoarthritis	Myself	Other____________
Diabetes	Myself	Other____________	Osteoporosis	Myself	Other____________
Drug Abuse	Myself	Other____________	Phlebitis	Myself	Other____________
Depression	Myself	Other____________	Rheumatoid Arthritis	Myself	Other____________
Epilepsy/Seizure	Myself	Other____________	Stroke	Myself	Other____________
Glaucoma	Myself	Other____________	Suicide Attempt	Myself	Other____________
Factor V Deficiency	Myself	Other____________	Thyroid Disease	Myself	Other____________
Heart Disease	Myself	Other____________	Tuberculosis	Myself	Other____________
High Blood Pressure	Myself	Other____________	Ulcer in GI tract	Myself	Other____________
Kidney Disease	Myself	Other____________	Venereal Disease	Myself	Other____________
Liver Disease	Myself	Other____________	High Cholesterol	Myself	Other____________
Hepatitis	Myself	Other____________	HIV/Immune Dx	Myself	Other____________
			Other________________	Myself	Other____________

Past Surgical History

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Review of systems As they relate to your health

Constitutional			**ENDOCRINE**			**ALLERGIC/IMMUNE**		
Weight Loss	Y	N	Loss of Hair	Y	N	Hives/Eczema	Y	N
Fatigue	Y	N	Heat/Cold intolerance	Y	N	Hay Fever	Y	N
Fever	Y	N	**Respiratory**			**PSYCHIATRIC**		
EYES			Cough	Y	N	Anxiety	Y	N
Glasses/Contacts	Y	N	Coughing Blood	Y	N	Depression	Y	N
Eye Pain	Y	N	Wheezing	Y	N	Mood Swings	Y	N
Double Vision	Y	N	Chills	Y	N	Difficulty Sleeping	Y	N
Have Cataracts	Y	N	**GASTROINTESTINAL**			HEMATOLOGY	Y	N
EAR,NOSE,THROAT			Heartburn/Reflex	Y	N	Easy bruising	Y	N
Difficulty Hearing	Y	N	Nausea/Vomiting	Y	N	Gums Bleed Easily	Y	N
Ringing in Ears	Y	N	Constipation	Y	N	Enlarged Glands	Y	N
Vertigo	Y	N	Change in BMs	Y	N	**MUSCULOSKELETAL**		
Sinus Trouble	Y	N	Diarrhea	Y	N	Joint Pain/Swelling	Y	N
Nasal Stuffiness	Y	N	Jaundice	Y	N	Stiffness	Y	N
Frequent Sore Throat	Y	N	Abdominal Pain	Y	N	Muscle Pain	Y	N
CardioVascular			Black or Blood BM	Y	N	Back Pain	Y	N
murmur	Y	N	**GENITOURINARY**			**SKIN**		
Chest Pain	Y	N	Burning/Frequency	Y	N	Rash/Sores	Y	N
Palpitations	Y	N	Nighttime	Y	N	Lesions	Y	N
Dizziness	Y	N	Blood in Urine	Y	N	Itching Burning	Y	N
Fainting Spells	Y	N	Erectile Dyfunction	Y	N	**NEUROLOGICAL**		
Shortness of Breath	Y	N	Abnormal Discharge	Y	N	Loss of Strength	Y	N
Difficulty lying Flat	Y	N	Bladder Leakage	Y	N	Numbness	Y	N
Swelling Ankles	Y	N				Headaches	Y	N
						Tremors	Y	N
						Memory Loss	Y	N

Date ______________ Name __________________________ DOB ___________

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for LAWRENCE S HAN DPM

Signed____ Date:__________________

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed____ Date:__________________

- I authorize LAWRENCE S HAN DPM to release medical information required to process my claim

Signed____ Date:__________________

- I have read and understand the Financial Policy for LAWRENCE S HAN DPM

Signed____ Date:__________________

- I authorize LAWRENCE S HAN DPM to obtain/have access to my medication history

Signed____ Date:__________________

- I authorize my provider's office to contact me by mobile phone

Signed____ Date:__________________