RAY FOOT & ANKLE CENTER

Mark J. Ray, DPM

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PATIENT INFORMATION SHEET **(Revised 12/2018)**

Patient's Last Name _____ First Name _____ Middle Initial _____

SS# _____-_____-_____ Date of Birth _____-_____-_____ Age _____ Sex F ◯ M ◯

Address _____ City _____ State ____ Zip _____+_____

Home Phone _____-_____-_____ Cell Phone _____-_____-_____ Other Phone _____-_____-_____

Marital Status:- Single Married Divorced Widowed Separated What # should we use to contact you first?_____

Email: _____@_____ Ethnicity: Caucasian ◯ Hispanic ◯ African ◯ Other ◯

Employer:_____ Phone: _____-_____-_____ Retired ☐

What is your occupation _____ Does it involve standing ☐ or sitting ☐

Primary Care Physician _____ Date Last Seen: _____/_____/_____

Emergency Contact: _____ Relationship: _____ Phone _____-_____-_____

Who can we leave a message with if you are not available? _____ (Relationship:_____)

PHARMACY:_____ Location:_____ Phone:_____

DESCRIBE THE REASON YOU ARE BEING SEEN TODAY - _____

How long has this bothered you? _____ Pain level w/10 being most severe - _____ / 10

What treatment(s) have you tried for this condition? _____

How did you hear about Dr. Ray? _____PCP Referral _____Friend _____Sign _____Radio _____Internet _____Other

MEDICAL INFORMATION

CURRENT MEDICATIONS	DOSAGE	**ALLERGIES**	REACTION

VITAL SIGNS: **Height ___'___"** **Weight _____** lbs. **Blood Pressure _____ / _____**

(Write additional medications/allergies on back)

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PATIENT NAME:_____ **Date of Birth** ____/____/_____

PATIENT HISTORY & PHYSICAL

Check any of the following medical issues you may have:

☐ ALCOHOLISM	☐ ALLERGIES	☐ ANXIETY	☐ ARTHRITIS	☐ ASTHMA	☐ BLOOD CLOT
☐ BLOOD DISORDER	☐ BREATHING ISSUES		☐ CANCER	☐ CIRCULATION	☐ CVA
☐ DEPRESSION	☐ DIABETES TYPE___		☐ GOUT	☐ HEART MURMUR	☐ HEPATITIS
☐ HIV	☐ HIGH CHOLESTEROL		☐ HYPERTENSION	☐ HEART DISEASE	
☐ KIDNEY DISEASE	☐ LIVER		☐ MENTAL ILLNESS	☐ MUSCULOSKELETAL	
☐ NEUROPATHY	☐ SKIN DISORDERS		☐ SLEEP APNEA	☐ STOMACH/BOWEL ISSUES	
☐ STROKE	☐ THYROID (SPECIFY:_____)			☐ OTHER _____	

Are you pregnant? _____

SURGICAL HISTORY: NONE _____ SURGERIES: _____

_____

Do you have any artificial joints? ____ (Where? _____) Do you have an artificial heart valve? _____

SOCIAL HISTORY

DO YOU SMOKE? ☐ **YES** How many packs per day? ___ For how long? ____ **FORMER** ☐ **NEVER** ☐

DO YOU DRINK ALCOHOL? ____ **Daily** (5-7 days/week) ____ **Social/Occasionally** ____**NO/RARELY**

Do you exercise regularly? ____ If so, what exercises regularly:_____

FAMILY HISTORY – Is there any family history (blood relative) of the following:**INDICATE FAMILY MEMBER**

ALZHEIMERS -	ARTHRITIS -	BLEEDING DISORDER -
BLOOD CLOT -	CANCER -	CATARACTS -
CIRCULATION ISSUE-	DEPRESSION -	DIABETES -
EMPHYSEMA -	HEART DISEASE -	HYPERTENSION -
NEUROLOGICAL -	STROKES -	OTHER -

Date of last: FLU SHOT _____/_____/_____

Have you had a pneumonia shot? Yes_____ No_____

Have you fallen in the last 12 months? ◯ Yes ◉ No Were you injured? ◯ Yes ◯ No

PATIENT HAS/HAS NOT COMPLETED THE FOLLOWING:

DO NOT RESUSCITATE ORDER _____YES _____NO
LIVING WILL ORDER _____YES _____NO
DURABLE POWER OF ATTORNEY _____YES _____NO

PRIVACY: We will keep your information confidential/no public reporting. The phone # & address you provide will be used to correspond with you for appointments, billing, etc. We also may leave messages if you are unavailable.
The information I have supplied is correct to the best of my knowledge. I understand that I am responsible for notifying Ray Foot & Ankle Center of any & all updates to my medical history. I authorize payment of medical benefits to Dr. Mark Ray. I authorize release of any medical information necessary to process claims & for Dr. Ray's office to retrieve my medication history. I have received/read or had the opportunity to receive/read the HIPAA privacy practices notice. I also give my consent to Dr. Ray to perform any and all treatments deemed necessary towards the diagnosis & treatment of my condition(s). I am also aware that I may be responsible for any monies that are not paid by the insurance, are not a covered benefit or reflect my deductible, copayment, coinsurance, etc.

PATIENT SIGNATURE_____ **DATE** _____/_____/_____
(Patient/Responsible Party)