Harold K. Cox, D.P.M. & Associates, Inc.
Medicine & Surgery of the Foot

913-596-1700
913-299-0748 (fax)

Please answer all questions fully.

PERSONAL DEMOGRAPHICS

Last Name	First Name	M.I.
Address		Apt. #
City	State	Zip Code
Home Phone #	Cell Phone #	
Date of Birth	Age	Social Security #

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Language ☐ English ☐ Spanish ☐ Other_________________

Race/ Ethnicity ☐ White ☐ African-American ☐ Hispanic ☐ Other________________

Spouse's Name		Phone #
Emergency Contact	Relationship	Phone #
Name of Guardian (if patient is a minor)		
Patient's Employer		Phone #

Work Type ☐ Retired ☐ Full-time ☐ Part-time ☐ Other_______________

☐ Sitting ☐ Semi-active ☐ Active

Shoe wear restrictions?____

Primary Care Physician Name_____________________________________ **Date Last Seen**___________________________

Preferred Pharmacy____ **City Location**____________________________

INSURANCE INFORMATION

Insurance # 1	Subscriber	Policy #
Group #	Date of Birth (Insured)	Social Security #
Insurance # 2	Subscriber	Policy #
Group #	Date of Birth (Insured)	Social Security #

AUTHORIZATIONS

I understand that by my signature below,

I hereby authorize benefits paid directly to Harold K Cox, DPM & Associates, Inc.
I understand I am responsible for any portion of my bill not covered by my insurance company.
I HEREBY AUTHROIZED RELEASE OF INFORMATION AND/OR MEDICAL RECORDS OF MYSELF TO ANY TREATING PHYSICIAN OR INSURANCE COMPANY.
The information authorized for release may include information which may be considered a communicable or venereal disease, which may include hepatitis, syphilis, gonorrhea, HIV or AIDS.
I voluntarily request Dr. Harold K. Cox as my podiatric Physician and such associates, assistants and other health care providers as they deem necessary, to treat my condition.
I understand I may be subject to a $25 fee for appointments not cancelled 24 hours in advance.
I have been informed of, and reviewed, and offered a copy of this office's HIPPA Policy.
I understand I am giving permission to access Surescripts or other online pharmacy sites for a list of my medications.

I give the following permissions for Harold K. Cox, DPM & Associates, Inc. to release information regarding my appointments, medical care, bills, and/or test results. I understand that I may change this information on file at any time.

- ☐ I do not wish to have any of my information released to anyone other than myself.
- ☐ I give permission for any messages to be left on an answering machine at home.
- ☐ I give permission to release my information to:

Name____ Relationship____

Name____ Relationship____

I understand all of the above and hereby state that the information given here is correct to the best of my knowledge.

____ _______________ ____

SIGNATURE OF PATIENT **DATE** **SIGNATURE OF RESPONSIBLE PARTY**

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VITALS

Height________ **Weight**________ **Shoe Size**________

What is your main concern about your feet or legs?________

- **Did you take the flu shot within the last 12 months?** ☐ **Yes** ☐ **No**

DIABETES

- Are you **diabetic**? ☐ **Yes** ☐ **No**
- Is your diabetes controlled by **oral medications only**? ☐ **Yes** ☐ **No**
- Is your diabetes controlled by **insulin**? ☐ **Yes** ☐ **No**
- Is your diabetes controlled by **diet only**? ☐ **Yes** ☐ **No**
- Number of years being diabetic________
- Average blood sugar range________

SOCIAL HISTORY

- Rate your **smoking/tobacco** use: ☐ **Never smoked** ☐ **Current LIGHT smoker** ☐ **Current HEAVY smoker** ☐ **Former smoker**
- Number of years________
- Amount per day________
- Date quit (if applicable)________
- Rate your **alcohol** intake: ☐ **Never** ☐ **Occasionally/Social drinker** ☐ **Daily** ☐ **Alcoholic**
- Rate your **caffeine** intake per day; ☐ **Never** ☐ **1-2 servings** ☐ **3-5 servings** ☐ **6+ servings**
- Rate your **recreational drug** use: ☐ **Never used** ☐ **Currently using** ☐ **Previously used**
- Do you take **sleeping pills**? ☐ **Yes** ☐ **No**
- WOMEN ONLY: Are you **pregnant**? ☐ **Yes** ☐ **No**
- Number of months pregnant________

ALLERGIES

☐ Aspirin	☐ Local anesthesia	☐ Other________	☐ Food Allergies________
☐ Betadine	☐ Morphine	________	________
☐ Codeine	☐ Penicillin	________	________
☐ Erithromycin	☐ Sulfa	________	________
☐ Iodine	☐ Tape	________	________
☐ Latex	☐ **NONE**	________	________

PRESCRIPTION MEDICATIONS

Please list all you are currently taking, including dosage

Drug Name	Dose	Times Taken Daily	For How Long?

VITAMINS AND SUPPLEMENTS

____

____

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PATIENT'S PAST MEDICAL HISTORY

☐ AIDS/Positive HIV Status	☐ Edema	☐ Polio	☐ Other_______________
☐ Alcoholism	☐ Emphysema	☐ Rheumatic Fever	
☐ Anemia	☐ Epilepsy	☐ Seasonal Allergies	
☐ Arteriosclerosis	☐ Frequent Colds or Sore Throat	☐ Skin Disease	
☐ Arthritis	☐ Gastric Reflux Disease	☐ Stomach or Duodenal Ulcers	
☐ Asthma	☐ Gout	☐ Stroke	
☐ Bleeding Tendencies	☐ High Blood Pressure	☐ Swollen Feet or Ankles	
☐ Bone Disease	☐ Hepatitis	☐ Thrombophlebitis (blood clots)	
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disorder	
☐ Cardiac Disease	☐ Liver Disease	☐ Tuberculosis	
☐ Congestive Heart Failure	☐ Nervous Disorder	☐ Tumors	
☐ COPD	☐ Pacemaker	☐ Varicose Veins	
☐ Diabetes	☐ Pneumonia	☐ **NOT APPLICABLE**	

REMARKS (If you checked any of the above, please explain, including date of onset, severity, persistent symptoms, and family physician currently caring for this condition if it is chronic):____

SURGERY AND HOSPITALIZATIONS

Type of Surgery			Date	Complications	
• Back surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
• Cancer surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
• Foot surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
• Heart surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
• Hip surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
• Knee surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
• Vascular surgery	☐ **Yes**	☐ **No**		☐ **Yes**	☐ **No**
☐ Other surgery______________				☐ **Yes**	☐ **No**
☐ Other surgery______________				☐ **Yes**	☐ **No**
☐ Other hospitalization__________				☐ **Yes**	☐ **No**
☐ Other hospitalization__________				☐ **Yes**	☐ **No**

☐ **NOT APPLICABLE**

FAMILY HISTORY

Has any BLOOD RELATIVE ever had any of the following?

☐ Alzheimer's Disease	☐ Emphysema	☐ Other_______________
☐ Arthritis	☐ Gout	
☐ Asthma	☐ Heart Disease	
☐ Bleeding Tendencies	☐ High Blood Pressure	
☐ Bunions	☐ Kidney Disease	
☐ Cancer	☐ Stroke	
☐ COPD	☐ Vascular Disease	
☐ Diabetes	☐ **UNKNOWN**	

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REVIEW OF SYSTEMS

CONSTITUTIONAL/GENERAL	GASTROINTESTINAL	MUSCULOSKELETAL
☐ General good health lately	☐ Abdominal pain	☐ Back pain
☐ Fever	☐ Constipation	☐ Foot pain
☐ Chills	☐ Diarrhea	☐ Joint pain
☐ Headaches	☐ Gastric reflux disease	☐ Morning stiffness
CARDIOVASCULAR	☐ Nausea	☐ Muscle pain
☐ Blood clots	☐ Vomiting	**NEUROLOGICAL**
☐ Chest pain	**GENITOURINARY**	☐ Alzheimer's disease
☐ Cold hands/feet	☐ Frequent urination	☐ Burning
☐ Congestive heart failure	☐ Kidney dialysis	☐ Numbness
☐ Deep vein thrombosis (DVT)	☐ Kidney disease	☐ Parkinson's disease
☐ Fainting	**IMMUNOLOGIC**	☐ Seizure
☐ Heart attack	☐ Allergic reactions	☐ Tingling sensation
☐ Heart palpitations	☐ Arthritis	☐ Tremors
☐ Heart surgery	☐ Gout	**PSYCHIATRIC**
☐ High blood pressure	☐ Seasonal allergies	☐ Anxiety
☐ Stroke	**INTEGUMENTARY**	☐ Depression
☐ Varicose veins	☐ Burning sensation of skin	☐ Forgetfulness, unusual
ENDOCRINE	☐ Dry, scaly skin	**RESPIRATORY**
Diabetes	☐ Eczema	☐ Asthma
☐ Insulin-dependent	☐ Itchiness	☐ Chest tightness
☐ Non-insulin dependent	☐ Non-healing wound	☐ COPD
☐ Fatigue	☐ Psoriasis	☐ Emphysema
☐ Thyroid problems	☐ Rash	☐ Shortness of breath
☐ Weight loss, unexplained	☐ Ulcer	☐ Sleep apnea
EARS/NOSE/MOUTH/THROAT	**LYMPHATIC**	☐ Wheezing
☐ Difficulty swallowing	☐ Anemia	**OTHER**
☐ Hearing problems	☐ Bleeding problems	
☐ Nasal congestion	☐ Edema	
☐ Sore throat	☐ Swelling in ankles/legs	
EYES		
☐ Legally blind		
☐ Wears glasses		

- **Did you take the flu shot within the past 12 months?** ☐ **Yes** ☐ **No**