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DELAND FOOT AND LEG CENTER 844 N. Stone St., Ste 208, DeLand, FL 32720
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PATIENT INITIAL HISTORY QUESTIONNAIRE and CONSENTS

Everything I answer is true, complete, and correct to the best of my knowledge. Failure to provide a truthful and complete medical history may result in serious complications, harm, or discharge from this office. You may be required to provide more medical information so that we can give you the best care and assessment.

- First Name:
- Last Name:
- Date of Birth:
- Gender Identify: Female / Male / Transgender / Other:
- Race:
- Ethnicity:
- Preferred Language:

- Street Address:
- Zip Code:
- State:
- County:
- **Email**:
- **Phone Number**:

Insurance Information

- Insurance Company:
- Plan Type:
- Member ID:
- Group :

- Secondary Insurance Company:
- Plan Type:
- Member ID:
- Group :

Payment Method

- We accept credit and debit cards. A 3.6% convenience fee is applied to all credit and debit card transactions. If you prefer to avoid this fee, we are happy to accept cash or check for your payment. Please confirm you understand _____ (initials)

Primary Responsible Party

- I am the responsible party
- Spouse
- Parent
- Guardian
- Other:

Responsible Party's Name, Address, Phone Number, Employer (if different)

Preferred Telephone for Routine Communication

Send Appointment Reminders Via (check all that apply)

- Email
- Text
- Voice Call

Emergency Contact Information

- Name:
- Phone Number:
- Zip Code:
- State:
- Email:

COVID-19 or Respiratory Infection Exposure
Has anyone in your HOUSEHOLD, or ANY of your ACQUAINTANCES tested positive for COVID-19 or respiratory infection within the last 14 days or have symptoms of an infection? - No - Yes

Appointment Details
- What problems are you coming in for?
  Provide detailed information for your appointment today (e.g., Right ankle sprain 2 weeks ago and the pain is getting worse even with Ibuprofen):

Medical History or Recent Changes
(Select all that apply)
- Arthritis - Osteoarthritis
- Arthritis: Psoriatic/Lupus/Rheumatoid/Ankylosing spondylitis
- Asthma
- Back pain/Spinal problems
- Bladder/Prostate Problems
- Blood disorder
- Bone infection
- Breast/GYN disorder
- Cancer
- Chronic ENT disorder
- Sleep Apnea
- Depression/Anxiety/B-Polar
- Diabetes
- Fibromyalgia
- Gastrointestinal disorder
- Gout
- Heart Disorder/AFib
- High Blood Pressure
- High Cholesterol
- Kidney Disease/CKD/Dialysis
- Liver disease
- Lung/COPD/Emphysema
- Musculoskeletal disorder
- Muscle/bone injury to foot or leg
- Neuropathy
- Neurologic/Spinal damage
- PAD/Peripheral arterial disease
- Parkinson's Disease
- Seizure
- Skin disorder
- Stroke
- Thyroid disorder
- Vascular Disease
- Varicose Veins/Venous Insufficiency
- Ulcerations/non-healing wounds

- Other: _____

Other Medical History, including Recent Surgeries, Hospitalizations or any Implantable Devices
- What surgeries have you had?

Past Testing - New and Established Patients
- (Select all that apply)
- ABI
- Bone Density
- Bone Biopsy
- Culture/Bacterial Testing
- CT
- Doppler Arterial
- Doppler Venous
- MRI
- Nerve Conduction Study/EMG
- Ultrasound foot
- ECHO
- Ultrasound carotids
- X-Rays
- Other: _____

Pharmacy Information
- What **local** pharmacy do you use?
  Include Name, Street, ZIP

Mail Order Pharmacy
- What mail order pharmacy do you use?
  Include Name and Phone Number

Food Insecurity Screening (Within the past 12 months)
- Within the past 12 months we worried whether our food would run out before we got money to buy more.
  - Often true - Sometimes true - Never true

- Within the past 12 months the food we bought just didn't last and we didn't have money to get more.
  - Often true - Sometimes true - Never true

Primary Care Provider
- Name:
- Phone Number:

Specialists
- Name:
- Specialty:
- Phone Number:

Specialists
- Name:
- Specialty:
- Phone Number:

Specialists
- Name:
- Specialty:
- Phone Number:

Referral Source
- How were you referred? (ie PCP, Endocrinologist)

Marital Status

-Married
-Single
-Divorced
-Widowed
-Separated
-Domestic Partner

Who do you live with: _____

Number of Children

- Children:

Your Education

- Years of Education/Highest Degree:

Your Work

-Job description:
- or Retired

Stress Level 1 Low to 10 High:

- 1-3
- 4-6
- 7-10

Sleep Quality – Undisturbed hours a night

- 1-3
- 4-6
- 7-10

Social Connections

-In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?

-In a typical week, how often do you get together with friends or relatives?

-In a typical year, how often do you attend church or religious services?

-Do you belong to any clubs or organizations such as church groups unions, fraternal or athletic groups, or school groups?

Smoking Status

- Never
- Former
- Cigarettes
- Pipe
- Cigar
- Snuff
- Chew
- Vaping
- E-cigarettes

- Quit Date:
- Packs/day:
- of years:

Alcohol Use

- Do you consume alcohol? - Yes - No

- Drinks/week:

- Is alcohol a concern for you/others? - Yes - No

Drug Use

- Have you ever used non-legalized drugs? - Yes - No

- Have you ever used needles to inject drugs? - Yes - No

Other Concerns - Weight: - Yes - No

NUTRITION/Diet

Dietary Preferences:

- Vitamins/supplements
- Normal
- ADA
- CVD/HTN/elevated BP
- Other:_____
- Keto
- Paleo
- Vegetarian
- Vegan
- Plant-based
- Weight-control
- Renal

Regular Exercise

- Do you exercise regularly?
  - Yes
  - No
- How long (minutes)?
- of times/week:

Safety Concerns

- Is violence at home a concern?
  - Yes
  - No
- Have you ever been abused?
  - Yes
  - No
- Do you fall frequently?
  - Yes
  - No
- Do you feel you are at risk for falling?
  - Yes
  - No

Concerns for Patients Over the Age of 65

- Do you have any concerns about activities of daily living?

Do you feel you have memory issues?

- Yes
- No

Medications: Prescription and Supplement (Oral and injectable), Devices (ie Dexcom Monitor)
- Any updates to your current medications and new medications or **provide a list**

Allergies
- Current & past allergies:

Family History
- Adopted: Yes or No
- Family History Unknown: Yes or No
- Family History Known (Listed Below):
  - Mental health disorder
  - Alcohol Issues
  - Breast Cancer
  - Colon Cancer
  - Prostate/Uterine Cancer
  - Lung Cancer
  - Diabetes
  - High Blood Pressure
  - High Cholesterol

- If you selected a family history above, who has it?
  (Father, Mother, Maternal Grandfather, Maternal Grandmother, Paternal Grandfather, Paternal Grandmother, Brother, Sister)

Immunization History
- Please note if you have had any of the immunizations below:
  - COVID
  - DTap (Tetanus & Pertussis)
  - Hepatitis A Series
  - Hepatitis B Series
  - HPV
  - Influenza (Flu)
  - Pneumonia
  - RSV
  - Shingles
  - Tetanus
  - Other: _____

Any additional information:

Everything I have answered is true, complete, and correct to the best of my knowledge. This form will become a part of your permanent medical record.

- Signature of Patient or Patient Authorized Representative: _____

- Date:

General Consent to Obtain Patient History or Medical Records
I give my permission to allow my healthcare providers, such as but not limited to: specialists, hospital, pharmacy, etc. to obtain my medical history from my pharmacy, my health plans, and my other healthcare imaging or testing providers.

- Signature of Patient or Patient Authorized Representative: _____

- Date:

Text/Email Consent

I authorize to receive text messages for **appointment reminders and feedback**. I understand there is a risk that unsecured text message communications has potential harm and could be read by a third party**. Therefore, SMS will not be used for any patient care-related communication.** I understand my mobile provider's standard rates for sending and receiving text messages will apply.

- Signature of Patient or Patient Authorized Representative: _____

- Date:

Acknowledge of Receipt of Notice of Privacy Practices
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I want) and understand the Notice.
Please be advised that the following forms are available upon your request:
-Patient Authorization of Release Health Information
-Patient Complaint Form
-Accounting of Disclosures Form
-Request for Correction/Amendment of Health Information
-Restriction Request Form
-Request for Confidential Communication

- Signature of Patient or Patient Authorized Representative: _____

- Date:

Consent for Transfer of Biological Specimen and Protecting DNA Privacy Act

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

Throughout your course of care at DeLand Foot and Leg Center, LLC, it may be medically necessary to obtain a biopsy, wound sample, blood, urine, tissue, or other types of biological specimen for analysis. This analysis will **NOT involve** the examination of DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state, and federal requirements. This consent does **NOT** authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.
You agree to the transfer and disposal of any and all biological specimens collected.

- Signature of Patient or Patient Authorized Representative: _____

- Date:

LIFETIME SIGNATURE AUTHORIZATION AND INSURANCE PAYMENT ORDER (REQUIRED)
I authorize the release of my medical information necessary to process my claims. I also authorize any request of payment of medical benefits to DeLand Foot and Leg Center, LLC or treating physician.

- Signature of Patient or Patient Authorized Representative: _____

- Date: