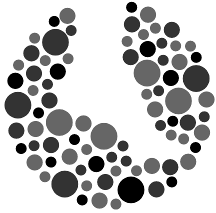



**9300 MEADOW VIEW DR., STE. 101**
**LENEXA, KS 66227**
**PHONE: 913-871-2183**
**FAX: 913-780-4834**

**PODIATRIC HISTORY & PHYSICAL & REVIEW of SYSTEMS (ROS)**

**Patient Name:** ___________________________________ **SS#**_______________**DATE** __________
**Preferred Name if any:** ____________**DOB:**___________**AGE:** ____**Home Phone**______________
**Cell Phone** __________________**Email** ______________________________________________
**Address**_________________________________________________________________________
**City, State, Zip**_____________________________________________________________________
**Physician**_______________________________________________**Ph#**_________________________
**Pharmacy** ________________________________ **Ph#**______________________________________
**Recommended by or referred by:** _____________________________________________________
**INSURANCE POLICYHOLDER:** ______________________________________ **DOB:** __________
**Emergency Contact:** __________________ **Relation to patient:** ______________ **Ph#**___________
**HT**________**WT** ____ **Shoe Size**____

***********STOP! DO NOT FILL IN BELOW THIS LINE ON THIS PAGE*********

**1) CC: CHIEF COMPLAINT:**
A) Location of problem_________________________________________________________
B) Duration of problem_________________________________________________________
C) Severity of problem_________________________________________________________
D) Changes in problem_________________________________________________________
E) Past treatment for problem____________________________________________________

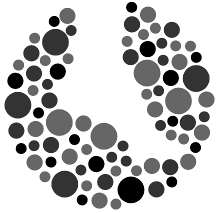
**2) PAST MEDICAL HISTORY:**
A) Current medications_________________________________________________________
B) Allergies ________________________________________________________________
C) Past surgeries_____________________________________________________________
D) Diabetes___ High BP ___ Heart Dz ___ Resp Dz___ PVD___ Arthritis___ Liver Dz __ Kidney Dz__
E) Illnesses_________________________________________________________________
F) Social History: Smoke _________ Alcohol _________

**3) PODIATRIC PHYSICAL EXAM:**
A) General __________________________________________________________________
B) Vascular__________________________________________________________________
C) Neurological_______________________________________________________________
D) Dermatological_____________________________________________________________
E) Musculoskeletal_____________________________________________________________
F) Biomechanical______________________________________________________________

**4) DIAGNOSIS** (ASSESSMENT) ____________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**5) TREATMENT** (PLAN)
A) ____________________________________________________________________________
B) ____________________________________________________________________________
C) ____________________________________________________________________________

**PODIATRY INFORMATION**

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Is this work related? (Y/N) ________ Describe your foot/ankle problem ________________________________
____________________________________________________________________________________.
How long has this been bothering you? ______________________
Any past problems with your feet or ankles? __________________________________________________

## ALLERGIES

**Are you ALLERGIC or sensitive to any of the following and, if so, describe your reaction:**
**Antibiotics (Penicillin, Sulfa, etc.)? _________________________ Reaction _________________________**
**Any Medicines? ________________________________________ Reaction _________________________**
**Tape? _________________________ Betadine (Iodine) _______________ Other ____________________**
**Any problems taking Aspirin or Ibuprofen (Advil, Motrin)? (Y/N) _______ Reaction ___________**
**Any problems with local anesthetics (Novocain, Lidocaine, Marcaine)? (Y/N) _______________Reaction _____________**

## General Medical Information:
## This information is important for our records and your health.

**Check any of the following you have, or have had a problem with:**

( ) High blood pressure ( ) Liver Disease ( ) Circulation ( ) Hormones
( ) Heart disease ( ) Kidney Disease ( ) Arthritis ( ) Tuberculosis
( ) Respiratory disease ( ) Healing ( ) Gout ( ) Skin
( ) PVD ( ) Rheumatic fever ( ) Anemia ( ) Stomach Ulcers
( ) Neurological disorder ( ) Diabetes ( ) Infections ( ) Cancer

**Is there a family (blood relative) history:**

( ) Diabetes ( ) Heart Disease ( ) Arthritis ( ) Bleeding Disorder
( ) Stroke ( ) Bunions ( ) Hammertoes ( ) Neurological disorder
( ) Flat feet ( ) Circulation problems in legs or feet

**Do you smoke?** Yes ___# of packs per day __ No ___ **Did you previously smoke?** Yes ___ No ___
**Do you drink alcohol or beer?** Yes __ No __
( ) Light Usage: 1-2 per week ( ) Moderate Usage: 1-2 per day ( ) Heavy Usage: 3 or more daily

Have you had any serious illnesses, if yes, please explain________________________________________
Have you had any major surgeries or hospitalizations, if yes, please explain________________________________________
Are you under a physician's care (Y/N)? _______ If yes, for what condition? ____________________________________

## ***PRESCRIPTION MEDICATIONS (WE ARE NOT AFFILIATED WITH OLATHE MED OR KU TO GAIN ACCESS TO YOUR MEDICATIONS SO PLEASE FILL OUT OR ATTACH MEDICATION LIST THANK YOU)***

What medications are you taking regularly? (Please include dosages): **SEE ATTACHED LIST: _____ NONE: _______**

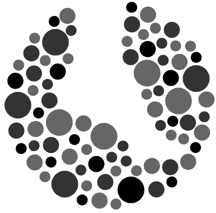
1.___________________________________________ 5. ___________________________________________

2.___________________________________________ 6. ___________________________________________

3.___________________________________________ 7. ___________________________________________

4.___________________________________________ 8. ___________________________________________

## HIPAA AUTHORIZATION FORM

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**Jayhawk Foot and Ankle clinics protect our patient's personal medical information to the upmost level. To share any of this information with anyone other than yourself we require your permission. At times this information is needed by other entities to provide appropriate medical care. This form is to help us be prepared to handle a request for your medical information in a way that you would prefer.**
**By initialing I consent Jayhawk Foot and Ankle Clinic to provide my medical information to the following parties if requested**

1. A. Family members:_______ D. Employer and/or government agency: _________

   B. Other medical professional: _______ E: Other: _______

   C. Insurance company including disability______

| ____________________________ | __________________________ | ______________ | _____________ |
|---|---|---|---|
| **Patient Name (Print)** | **Patient or Guardian Signature** | **Date of Birth** | **Date** |

## PATIENT FINANCIAL OBLIGATION

Patient Name **(PRINT):** _______________________________________________________
I understand that I am financially responsible for any and all services rendered by physicians and staff at Jayhawk Foot & Ankle Clinic. I also understand that in event that my insurance carrier does not make full payment of all charges within 60 (sixty) days after services are rendered, I am totally responsible for any and all balances thereof.

_______________________________________ ______________________
Signature Date

## APPOINTMENT POLICY

It is the policy of the practice to monitor and manage all appointments, no-shows, and late cancellations. Please arrive on time for all of your appointments as it is our goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are asked to call or leave a message at least 24 hours before their appointment time if possible. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care. In the event a patient arrives late as defined by "late arrival" to their appointment, our clinic reserves the right to request a rescheduling of your appointment. **In the event of three (3) documented cancellations or no-shows, we will not reschedule an appointment**. We appreciate your attention to our appointment policy.