FAR GA
Foot and Ankle Reconstruction Center of Georgia

Annual Update

Patient Name: _____ Date of Birth: _____ Age: _____
Last First MI
Social Security No: _____ Gender: Male/ Female Marital Status: Single/Married/Divorced/Widow
Circle One Circle One
Address: _____
Street City State Zip
Phone Numbers: _____
Home Mobile Work
Email Address: _____ Spouse's Name: _____

Pharmacy: _____ Pharmacy Phone: _____

Employer: _____ Title/Job: _____

Primary Care Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

PLEASE INCLUDE A COPY OF A PHOTO ID AND ALL INSURANCE CARDS

Primary Insurance Name: _____
Policy/Contract #: _____Group #: _____
Name of Policy Holder: _____Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN: _____

Secondary Insurance Name: _____
Policy/Contract #: _____Group #: _____
Name of Policy Holder:_____ Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN: _____

Other Insurance Coverage (Auto/Worker's Compensation)
Name of Company: _____
Policy/Contract #: _____Group #: _____
Name of Policy Holder:_____ Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN: _____
Claim #: _____
Adjustor: _____ Phone: _____
Case Manager: _____ Phone: _____

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List or attach a complete list of all CURRENT MEDICATIONS (Include how much and how often taken), including vitamins/supplements:

Allergies: (circle) NONE /Narcotics/NSAIDS/Penicillin / Sulfa / Aspirin / Contrast / Latex / Iodine / Shellfish / Tape
Gluten Intolerance / Food Allergies / Metal / Other: _____

PAST MEDICAL HISTORY (circle all that apply) *NONE*

Cancer: lung skin breast cervical prostate other: _____
Neurological: stroke seizures neuropathy
Skin: eczema dermatitis psoriasis ulcers
Psychiatric: bipolar depression anxiety dementia
Respiratory: emphysema asthma COPD
Eyes/Ears/Noses/Mouth and Throat: cataracts glaucoma hearing loss
Genitourinary: HIV STD: _____ UTI kidney stones kidney disease dialysis
Hematologic/Immunologic: anemia sickle cell bleeding disorder
Gastrointestinal: stomach ulcers acid reflux/GERD gallbladder disease hernia hepatitis
Cardiovascular: heart attack coronary disease irregular heart rhythm high blood pressure high cholesterol Raynaud's disease deep vein thrombosis pulmonary embolism peripheral vascular disease
Musculoskeletal: osteoarthritis rheumatoid arthritis fibromyalgia gout back pain foot deformity
Metabolic: diabetes hypothyroidism hyperthyroidism osteoporosis

Other: _____

PAST SURGERIES AND HOSPITALIZATIONS (circle all that apply) *NONE*

Amputations Other Vascular Bypass Coronary/Heart Bypass Angioplasty

Appendix Gallbladder Hysterectomy Hernia

Foot/Ankle Surgery (Please Be Specific): _____

Other: _____

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SOCIAL HISTORY

Height: _____ Weight: _____ Shoe Size: _____

Do you currently use illicit drugs (pain pills, marijuana, cocaine etc.)? YES/NO

Do you have a history of alcohol or drug abuse including prescription medications? YES/NO

Have you have ever used tobacco? YES/NO If yes, amount per day_____ Age began: _____ Age quit: _____

Do you ever drink alcohol? YES/NO If yes, How often: _____How much: _____

Is there a **family history** of any specific medical conditions or diseases? _____

_____

REVIEW OF SYSTEMS: (circle any symptom that you have had in the last 6 months) *NONE*

Constitutional/Endocrine: fever night sweats weight gain weight loss exercise intolerance chills malaise
Eyes: dry eyes irritation vision changes eye disease/injury _____ wearing glasses/contact lenses
Ears: difficulty hearing ear pain
Nose: frequent nosebleeds nose problems sinus problems
Mouth/Throat: sore throat bleeding gums snoring dry mouth oral abnormalities mouth ulcer teeth abnormalities mouth breathing ringing in ears sinusitis
Cardiovascular: chest pain on exertion arm pain on exertion shortness of breath when walking shortness of breath when lying down palpitations heart murmur light-headed on standing ankle swelling
Respiratory: cough wheezing shortness of breath coughing up blood sleep apnea
Gastrointestinal: abdominal pain nausea vomiting constipation change in appetite black/tarry stools diarrhea vomiting blood dyspepsia GERD
Genitourinary: urinary loss of control difficulty urinating increased urinary frequency hematuria incomplete emptying
Musculoskeletal: muscle aches muscle weakness arthralgias/joint pain back pain swelling in the extremities neck pain difficulty walking leg cramps osteoporosis fractures
Skin: abnormal mole jaundice rash itching dry skin skin lesion laceration non-healing wounds/areas changes in hair/nails psoriasis change in skin color breast lump
Neurologic: loss of consciousness weakness numbness seizures dizziness headaches migraines restless legs tremor gait dysfunction paralysis
Psychiatric: depression sleep disturbances feeling unsafe in a relationship restless sleep alcohol abuse anxiety hallucination suicidal thoughts mood swings memory loss agitation dementia delirium
Endocrine: fatigue increased thirst hair loss increased hair growth cold intolerance
Hematologic/Lymphatic: swollen glands easy bruising excessive bleeding anemia m. phlebitis
Allergy/Immunologic: runny nose sinus pressure itching hives frequent sneezing

Other: _____

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To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and staff of any changes in my medical status. I, the undersigned or as parent, legal guardian, or power of attorney of the undersigned hereby authorize the physicians and their assistants of the Foot and Ankle Reconstruction Center of Georgia to administer treatment as deemed necessary to myself or the patient below for whom I am responsible.

_____

Print Name of Patient

_____

Signature of Patient/Parent/Guardian/Power of Attorney

_____

Date