

**Grace Foot And Ankle Center  
Michael J Kim DPM**

**PATIENT INTAKE FORM**

Name: \_\_\_\_\_ Gender: \_\_\_ M \_\_\_ F

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Windowed \_\_\_ Partner \_\_\_ Legally separated

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Primary Spoke Language: \_\_\_\_\_

Employment Status: \_\_\_ Full-time \_\_\_ Part-time \_\_\_ Not Employed

Student Status: \_\_\_ Full-time \_\_\_ Part-time \_\_\_ Not a student

**Race:**

American Indian or Alaska native \_\_\_ Native Hawaiian or other Pacific Islander \_\_\_ Asian \_\_\_

Black or African America \_\_\_ White \_\_\_ Hispanic/Latino \_\_\_ Unknown \_\_\_

**Ethnicity:**

Hispanic or Latino \_\_\_ Not Hispanic or Latino \_\_\_

Primary Care Physician: \_\_\_\_\_

Referred by \_\_\_\_\_

Vascular Surgery: \_\_\_\_\_

Neurologist: \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Endocrinologist: \_\_\_\_\_

Nephrologist: \_\_\_\_\_

Rheumatologist: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Pharmacy phone #: \_\_\_\_\_

\*\*\*Please describe your foot/ankle problem ( include date of injury if applicable) \*\*\*

\_\_\_\_\_  
\_\_\_\_\_

How long has the problem been present ? \_\_\_\_\_

Have you had any treatment or taken anything for it? \_\_\_\_\_

Have you seen someone for this already? \_\_\_ No \_\_\_ Yes Whom? \_\_\_\_\_

Have you had any prior foot/ankle problems? If yes, please describe: \_\_\_ No \_\_\_ Yes \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**ALLERGIES**

**Please check all allergies:**

\_\_\_\_\_ Medications: \_\_\_\_\_

\_\_\_\_\_ Foods: \_\_\_\_\_

\_\_\_\_\_ Tapes or Topical Skin Sensitivity: \_\_\_\_\_ Other: \_\_\_\_\_

What types of reactions have you experienced? \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**

Please list all medications and the dosages

1. \_\_\_\_\_

6. \_\_\_\_\_

2. \_\_\_\_\_

7. \_\_\_\_\_

3. \_\_\_\_\_

8. \_\_\_\_\_

4. \_\_\_\_\_

9. \_\_\_\_\_

5. \_\_\_\_\_

10. \_\_\_\_\_

**Personal Medical History:**

**\*\* Check those that apply to you now or have applied to you in the past \*\***

\_\_\_\_\_ Diabetes \_\_\_\_\_ Average Blood Sugar

\_\_\_\_\_ Anemia/Blood Disorders

\_\_\_\_\_ Liver Disorder

\_\_\_\_\_ Pneumonia

\_\_\_\_\_ Kidney Disease

\_\_\_\_\_ Drug/Alcohol Abuse

\_\_\_\_\_ Dialysis \_\_\_\_\_ MWF or \_\_\_\_\_ TTHSA

\_\_\_\_\_ Prolong Bleeding Time

\_\_\_\_\_ Asthma

\_\_\_\_\_ Stomach/Ulcer Disorder

\_\_\_\_\_ Emphysema

\_\_\_\_\_ Thyroid/parathyroid Disease

\_\_\_\_\_ Heart trouble

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Stroke

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Chest pain on Mild Exertion

\_\_\_\_\_ Psychiatric treatment

\_\_\_\_\_ Gout

\_\_\_\_\_ Emotional Problems/Tension

\_\_\_\_\_ Blood Clots

\_\_\_\_\_ Hepatitis/HIV

\_\_\_\_\_ Tumor/Abnormal Growth/Cancer

\_\_\_\_\_ Sexually Transmitted Disease

\_\_\_\_\_ Ear, Nose, Throat Disorder

\_\_\_\_\_ Prostate Disorder

\_\_\_\_\_ Asthma/Hay Fever/Shortness of Breath

\_\_\_\_\_ Frequent Headache/migraines

\_\_\_\_\_ Other

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**SURGICAL HISTORY**

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Has any **family member** had any of the following ( please indicate relationship)

Cancer: _____	Diabetes: _____
Heart Trouble: _____	High Blood Pressure: _____
Kidney Disease: _____	Mental/Emotional Disease: _____
Tuberculosis: _____	Stroke: _____
Arthritis: _____	Emphysema: _____
Blood Clots: _____	Other: _____

**PATIENT INFORMATION**

Do you smoke currently? \_\_\_ Yes \_\_\_ No      How may packs per day? \_\_\_\_\_      For how many years? \_\_\_\_\_  
 Have you smoked previously? \_\_\_ Yes \_\_\_ No      When did you quit? \_\_\_\_\_  
 Number of Caffeine drinks per day? \_\_\_\_\_      Amount of alcohol consumed per week \_\_\_\_\_  
 For women only: Are you pregnant? \_\_\_\_\_      How many months? \_\_\_\_\_

Please complete the following:

Height: \_\_\_\_\_      Weight: \_\_\_\_\_      Shoe Sizes: \_\_\_\_\_      Occupation: \_\_\_\_\_

Is there any other information you would like us to be aware of \_\_\_ No \_\_\_ Yes

Please describe: \_\_\_\_\_

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\*\*Please circle off all that currently apply to you \*\*

**MEDICAL CONDITONS:**

Diabetes     High Blood Pressure     Heart Disease     Heart Murmur     Heart Valve  
 Seizure     Asthma     Rheumatic Fever     Hepatitis     Stroke  
 Gout     Stomach Ulcer     Anemia     Liver Disease     Circulation  
 Cancer     Infections     Nerve Problems     Thyroid     Kidney Disease  
 Bleeding     Scarring     Tuberculosis     HIV     Hormones  
 Arthritis     Chills     Seizures     Fever

**Muscular/Skeletal:**  Back Pain     Joint Pain     Joint Redness     Neck Pain  
 Joint Swelling     Leg Cramps     Morning Stiffness     Stiffness  
 Muscle Tenderness     Weakness of Muscles     Difficulty with Walking

**Neurological:**  Burning in feet, tingling in feet or toes     Numbness     Tremors

**Psychiatric:**  Addiction     Attempted Suicide     Depression     Memory Loss     Panic Attacks

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my accounts, including collection fees and attorney costs.

**I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due from me directly.**

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Grace Foot And Ankle Center permission to obtain release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Grace Foot And Ankle Center office policy.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\*\* If not patient, relationship to patient:

Parent     Power of Attorney     Legar Guardian     Other