momentum.
foot and ankle clinic.

New Patient Intake Form

Patient Information

Name _____ **DOB** _____

Address _____ **Gender** _____

City, State, Zip _____ **SS#** _____

Home Phone _____

Cell Phone _____

Email _____

Occupation _____

Permission to leave voice message?
Yes No

Preferred method of communication for appointment confirmation & reminders?
Phone Email Text

Race African American American Indian/Alaska Native Asian Hispanic/Latino
Native Hawaiian or Other Pacific Islander White Prefer Not to Answer

How did you hear about us? _____

Primary reason for your visit? _____

Emergency Contact Information

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

Preferred Providers

Primary Care Physician _____ **Phone** _____

Address _____ **Last Visit** _____

Preferred Pharmacy _____ **Phone** _____

Address _____

Worker's Compensation Claim

Is this related to a worker's compensation claim? Yes No

Motor vehicle accident? Yes No

Insurance Company _____ **Claim#** _____

Adjuster Name & Phone _____ **Date of Injury** _____

Insurance Information

Primary Insurance _____

Policy Holder _____

DOB _____

Relationship _____

Secondary Insurance _____

Policy Holder _____

DOB _____

Relationship _____

Medical History

Height _____ **Weight** _____ **Shoe Size/Width** _____

Review of Systems

Please check the box if you have any of the following health conditions:

AIDS/HIV □	Chemical Dependency □	High Blood Pressure □	Skin Sensitivity □
Anemia □	Chest Pain □	High Cholesterol □	Varicose Veins □
Arrhythmia □	Cysts or Masses □	Kidney Disease □	Other History:
Arterial Plaque/Stenosis □	Deep Vein Thrombosis □	Liver Disease □	
Arthritis □	Diabetes □	Low Blood Pressure □	
Artificial Heart Valves □	Foot/Leg Ulcers □	Numbness □	
Asthma □	Gout □	Peripheral Vascular Disease □	
Back Problems □	Heart Disease □	Psychiatric Care □	
Bleeding/Clotting Disorders □	Hemophilia □	Radiation Treatment □	
Cancer □	Hepatitis of Jaundice □	Shortness of Breath □	

Do you have swelling in your limbs? Arms Legs No

Do you have pain in your limbs? Arms Legs No

If you answered yes to either question, please describe:

How often? _____

Which region? _____

When? (at rest, exercise or other) _____

Food/Drug Allergies & Reactions _____

Current Home Medications *(please include prescription, non-prescription and over-the-counter products)*

_____

_____

Past Hospitalizations/Surgeries _____

_____

For Diabetics Only

Name of Provider *(managing your diabetes)*

Name of Eye Doctor _____ **Last Eye Exam** _____

Name of Kidney Doctor _____ **Last Visit** _____

What was your last A1c value? _____ **Date** _____

Family History

	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alive or Deceased							
Diabetes							
Heart Disease							
Stroke							
Cancer							

Social History

Tobacco Use

Do you smoke? Yes, current smoker No, former smoker No, never smoked

If yes, how much per day? _____

If former smoker, how long ago did you quit? _____

Alcohol Use

How often do you drink? Never Rarely Moderately Daily

Recreational Drug Use

Do you use recreational drugs? Yes No

If yes, please explain _____

Consent: I certify that the above information is true and complete to the best of my knowledge. I give permission to Momentum Foot & Ankle Clinic to administer and perform procedures as may be deemed necessary in my diagnosis and treatment.

_____ _____

Patient/Parent/Guardian Signature **Date**