Fort Mitchell
2300 Chamber Center Dr
Suite 100
Fort Mitchell, KY 41017
859-331-2440

PROGRESSIVE PODIATRY

Cincinnati
4415-B Aicholtz Rd
Suite 200
Cincinnati, OH 45245
513-943-0400

PATIENT REGISTRATION

Your information is private and confidential and will only be used for your medical care.

1 PATIENT INFORMATION

Patient Name (Last, First, Middle):_____ Date of Birth:_____ Sex:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Email Address:_____

Do you have a legal guardian or healthcare power of attorney?

☐ Yes If yes, Name:_____ Relationship:_____ Phone Number:_____
☐ No

Emergency Contact:_____ Relationship:_____ Phone Number:_____

Primary Care Doctor:_____ Date Last Seen:_____

Pharmacy:_____ Location:_____

2 PAYMENT RESPONSIBILITY

Who is responsible for payment?

☐ Self

☐ Other (Please complete information to the right)

Name:_____ Relationship:_____

Phone Number:_____ Home Address:_____

City:_____ State:_____ Zip:_____

3 INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company:_____ Phone Number:_____

Member ID:_____ Group Number:_____

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Company:_____ Phone Number:_____

Member ID:_____ Group Number:_____

Are you the policy holder?

☐ Yes ☐ No

If no, please complete the following:

Policy Holder's Name: _____ Date of Birth:_____

Patient's Relationship to Policy Holder: _____ Sex:_____

Home Address:_____ City:_____ State:_____ Zip:_____

☐ Same address as the patient

PROGRESSIVE PODIATRY

MEDICAL HISTORY

Patient Name:_____
Date:_____

Your answers help us provide the best possible care.
Please complete all sections to the best of your ability.

1. CURRENT MEDICATIONS

List all prescription medications, OTC medications, vitamins and supplements you take regularly.

☐ I brought my current medication list ☐ No Current Medications

Medication Name	Strength/Dose	How Often?

Need more space? Please attach your medication list or use the back of this page.

2. ALLERGIES

☐ None Known ☐ Latex ☐ Tape ☐ Iodine
☐ Anesthesia ☐ Shellfish ☐ Other:_____

Medication Allergies:_____

Food Allergies:_____

Other Allergies:_____

3. PREVIOUS SURGERIES/HOSPITALIZATIONS

List all surgeries and hospitalizations with approximate dates.

_____
_____
_____
_____
_____

4. MEDICAL CONDITIONS

☐ Acid Reflux
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Abnormal Bleeding
☐ Back Trouble
☐ Blood Clots
☐ Cancer
☐ Diabetes Type:_____
☐ Fibromyalgia
☐ Gout
☐ Heart Attack
☐ Heart Attack
☐ Heart Disease/Failure
☐ Hepatitis Type:_____
☐ HIV/AIDS
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Neuropathy
☐ Open Sores
☐ Sickle Cell Anemia
☐ Skin Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ None of the Above
☐ Other:_____
_____
_____

5. SOCIAL HISTORY

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Partnered

Alochol Use
☐ Never
☐ Former
☐ Current
Drinks/week:____

Tobacco Use
☐ Never
☐ Former
☐ Current
Type:
☐ Cigarettes ☐ Vape
☐ Cigars ☐ Smokeless
Packs/day:_____ Years:_____

Recreational Drug Use
☐ Never
☐ Former
☐ Current
Type:_____

Exercise
☐ None
☐ 1-2 Days/week
☐ 3-5 Days/week
☐ Daily
Type:_____

Occupation
_____
_____
_____
Time on Feet:_____

6. ADDITIONAL PATIENT INFORMATION

For all patients:

Has the patient received the flu vaccination for the current month?
☐ Yes ☐ No If No, what was the reason?
☐ Patient Allergy
☐ Patient Declined
☐ Vaccine Unavailable

For patients 65 years of age or older

Have you had the pneumonia vaccine?
☐ Yes ☐ No

Do you have a living will or someone to make healthcare decisions on your behalf?
☐ Yes ☐ No

PROGRESSIVE PODIATRY

TODAY'S VISIT

Help us understand why you're here today

Patient Name:_____
Date:_____

HOW WOULD YOU DESCRIBE YOUR PAIN?

Check all that apply:

- ☐ Sharp
- ☐ Burning
- ☐ Tingling
- ☐ Radiating
- ☐ Dull
- ☐ Stabbing
- ☐ Numbness
- ☐ Aching
- ☐ Throbbing
- ☐ Itching
- ☐ No Pain
- ☐ Other:_____

PAIN LEVEL

Circle your current pain level

No Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

SINCE IT STARTED...

- ☐ Getting Better
- ☐ About the Same
- ☐ Getting Worse

WHAT MAKES IT WORSE?

- ☐ Walking
- ☐ Standing
- ☐ Running
- ☐ Exercise
- ☐ Dress Shoes
- ☐ High Heels
- ☐ Close Toed Shoes
- ☐ Resting
- ☐ Daily Activities
- ☐ Other:_____

WHERE IS YOUR FOOT PAIN?

Please mark the area(s) on the diagram.

Top of Left Foot

Top of Right Foot

Bottom of Left Foot

Bottom of Right Foot

Inside of Left Foot

Inside of Right Foot

Outside of Left Foot

Outside of Right Foot

WHAT MAKES IT BETTER?

_____

_____

_____

WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM?

- ☐ Ice
- ☐ Heat
- ☐ NSAIDS
- ☐ Tylenol
- ☐ Orthotics/Inserts
- ☐ Physical Therapy
- ☐ Injection
- ☐ Surgery
- ☐ Other:_____

_____

_____

_____

HOW DOES THIS AFFECT YOUR DAILY LIFE?

- ☐ Walking
- ☐ Work
- ☐ Exercise/Sports
- ☐ Sleep
- ☐ Driving
- ☐ Daily Activities
- ☐ Other:_____

_____

_____

_____

WAS THIS PROBLEM CAUSED BY AN INJURY?

☐ Yes ☐ No

If yes, please describe:_____

_____

Was it a work-related injury? ☐ Yes ☐ No

PATIENT CONSENT TO TREAT

I certify that the information I have provided is true and complete to the best of my knowledge. I authorize Progressive Podiatry to evaluate and treat my condition and understand that I am responsible for informing the office of any changes to my medical information.

Patient Signature:_____ **Date:**_____

Printed Name:_____ **Parent/Guardian Signature:**_____