

MEDICAL HISTORY

CHECK OFF in the proper column conditions you have **NOW** -or- **HAD**.

NOW OR in **PAST**

- ...Skin problems: _____
- ...Scars (excess)/ keloids _____
- ...Hair/Nails: _____
- ...Eye problems: _____
- ...Hearing: _____
- ...Smell (sense of): _____
- ...Sinuses: _____
- ...Stroke /CVA _____
- ...Seizures: _____
- ...Headaches: _____
- ...Tremors or Parkinsonism _____
- ...Thyroid: _____
- ...Heart prob's: _____
- ...Lung / breathing: _____
- ...Stomach: _____
- ...Liver prob's: _____
- ...Hepatitis, Infect: A B C D _____
- ...Pancreas: _____
- ...Intestines: _____
- ...Adrenal gland: _____
- ...Kidney prob's: _____
- ...Bladder: _____
- ...Genital / menstrual : _____
- ...STDs: (Sexual infections) _____
- ...Blood pressure: (high /low) _____
- ...Overweight / Obesity : _____
- ...Cholesterol, high: _____
- ...Diabetes: (diet /pills / insulin) _____
- ...Hormones: (replace/add) _____
- ...Anemia: (family / inherited) _____
- ...Blood clots: (legs,lungs,head) _____
- ...Bleeding prob's: _____
- ...Muscles: (MS; MD) _____
- ...Fibromyalgia; fibromyositis _____
- ...Immune disord: (HIV or AIDS) _____
- ...Cancer (Internal): _____
- ...“Allergies” (List above right.) _____
- ...Lupus / Scleroderma _____
- ...Veins, legs (Varicosed / bad) _____
- ...Arteries, legs (Blocked / bad) _____
- ...Arthritis/Gout/Rheumatoid _____
- ...Osteoporosis; (brittle bones) _____
- ...Back /Spine: (prob's:/ injury) _____
- ...Hip: (prob's:/ injury) _____
- ...Knee (prob's:/ injury) _____
- ...Leg: (prob's / injury) _____
- ...Ankle: (prob's:/ injury) _____
- ...Foot: (prob's:/ injury) _____
- ...Amputee: (toe/foot/leg) _____
- ...Tobacco: (smoke or chew) _____
- ...Psychological prob's: _____
- ...Addictions (dependencies) _____
- ...Retardation (mental) _____
- ...Senility (Alzheimer's) _____
- ...Work-disabled (now) _____
- Walking (prob's as child) _____

NOW and in **PAST**
- or check-
IF NONE AT ALL:- NOW OR IN PAST: []

Name of _____
Your Pharmacy: _____ in town of: _____

LIST (below) **ALL** of your **ALLERGIES** to medicines and to things, foods, chemicals, animals, etc.: _____
Check here **IF NONE:** []

LIST (below) **ALL** **RX / PRESCRIPTION DRUGS** you are taking **NOW** or have **AVAILABLE** to you to use as needed: _____
Check here **IF NONE:** []

LIST (below) **ALL** **O.T.C.** drugs, vitamins, dietary and herbal supplements which you have **and take regularly:** _____
Check here **IF NONE:** []

CHECK off and **FILL IN:**

MY HEALTH is **USUALLY:** Excellent!; or Good; or Fair; or Poor!

My Height: ___' ___" **My Weight:** _____ lb. **Shoe Size:** _____ & **Width:** _____

During the day, I mostly: SIT; STAND; WALK; CLIMB; RUN

CIRCLE your **PAST SURGERIES** in the list below:

- **FOOT Surgery****
- Ankle; Heel
- Achilles tendon
- Arch – instep
- Bunion; bunionette
- Toe joint
- Toenail
- Growth, tumor
- Nerve; neuroma
- Spur, bone
- Amputation
- **Orthopedic Sx****
- Neck
- Shoulder
- Arm, Elbow
- Wrist, Hand
- Back, spine
- Pelvis, Hip
- Thigh, Knee
- Leg, ankle
- **Skin Surgery****
- Biopsy; Abscess
- Growth, tumor

- Graft, Laser
- Plastic, Scar-repair
- Hair transplant
- Maxillo-Facial Sx:**
- Dental Implants
- Cosmetic; Botox Inj.
- Reconstruction
- **Eye Surgery****
- Cataracts, Lens
- Laser Eye Sx
- Keratotomy
- Muscle balance
- Plastic, Ducts
- **Neck, Chest Sx****
- Throat, Tonsils
- Glands,
- Trachea,
- Lung, Lobes
- Lung collapsed
- Heart –Cardiac Sx:**
- Angioplasty, Stent
- Bypass: 1, 2, 3, 4, 5
- Valve(s)

- Pacemaker implant
- Defibrillator implant
- Transplant, human
- Artificial Heart
- **Breast Sx****
- Lumpectomy
- Enlarge, Reduce
- Mastectomy
- Reconstruct, repair
- **G.I. Tract Sx****
- Esophagus
- Stomach
- Intestine; Appendix
- Colon; Polyps
- Hemorrhoids
- **Fem' Reprod. Sx****
- D&C, Biopsy
- Laparoscopy
- Tubal Ligation
- Hysterectomy
- C-Section, Ovary
- Repair, plastic

- **Male Reprod. Sx****
- Circumcision
- Testes; Implant
- Prostate; Hernia
- Repair, plastic
- **Abdominal Sx****
- Hernia; Gallbladder
- Laparoscopy; Biopsy
- Bladder
- **Leg Circulatn Sx****
- Angiogram (inj. dye)
- Veins: tie, strip, stent
- Arteries: Graft, By-pass, stent, balloon angioplasty
- Other Surgeries:**
- Transfusion(s)
- Body piercings
- Tattoos
- If NO Sx's at all, then check:** [] **none**

Implants in my body now: _____

Organs transplanted in: _____

Tumors removed from: _____

Other Sx's: _____

FAMILY History:

What special foot / leg problems did these following blood relatives now have or **HAD**:

Mom: UNK; No; YES: _____

Dad: UNK; No; YES: _____

Sis: UNK; No; YES: _____

Bro: UNK; No; YES: _____

OTHER information you feel that the doctor should know about **YOU:** _____

Dr. Ken's Foot Health Services

Kenneth E. Sokolowski, D.P.M.

APMA-Approved Surgical Residency at Northlake Community Hospital, Illinois
Member: American, Connecticut and Hartford County Podiatric Medical Associations
Surgical, Orthopedic, Medical and Preventative Care of Your Feet
Serving Wethersfield and her sister communities since 1975 !



CHECK OFF EACH ITEM below which applies to YOU, the patient:

Courtesy Title:

- "MISS"
 - "MS"
- "MRS."
 - "MR."
- "JUDGE"
 - "Attorney"
- "REVEREND"
 - "Father"
 - "Sister"
- "DOCTOR"
 - "Professor"
- "CHIEF"
 - "Officer"
 - "Lieutenant"
 - "Detective"
- _____

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PLEASE check off your current Marital status:

- Unmarried
- Married
- Domestic Partner
- Widowed

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PLEASE indicate status of your EMPLOYMENT:

- Homemaker
- FULL-time
- Self-employed
- PART-time
- Retired
- Between Jobs
- Unemployed

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If you are a STUDENT, are you...?

- FULL-time
- PART-time

New patient information form
Reviewed by Doctor on: _____

Office use only: Use space to right for contact info with a family member, friend, or conservator, etc.

FHS-NP1-FORM-070622.PUB
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Use DARK ink! Print CLEARLY: ~ ~ Patient Application Form for Adult (or for Responsible Party of Child/Ward)*

ADULT FULL NAME: FIRST, MID. INIT., LAST () AGE Date of BIRTH: MM - DD - YYYY

STREET ADDRESS / RESIDENCE APT.# HOME TELEPHONE NUMBER

TOWN OR CITY STATE ZIP CODE SOCIAL SECURITY NUMBER (Required !)

[] Cellular phone -or- [] Pager Number E-MAIL Address at HOME (personal)

WHO brings you here and back home; their NAME and their PHONE NUMBER

* CHILD's / WARD's FULL NAME BIRTH DATE AGE CHILD's Social Security # (Required!)

CHILD'S FULL ADDRESS - [if different than that of the responsible party (adult)] PHONE NUMBER

NAME of PHYSICIAN who is responsible for your/ Pt's OVERALL health care:

DR. IN: LAST SEEN : CITY or town DATE

Please indicate what TYPE of physician your primary doctor is:
[] Primary care; [] Internist; [] Ob-Gyn; [] Pediatrician; [] other: _____

YOUR CURRENT EMPLOYMENT INFORMATION: IF RETIRED, CHECK HERE: []

NAME OF PRIMARY EMPLOYER TYPE OF WORK YOU PERFORM or DID PERFORM

STREET ADDRESS AT WORK WORK PHONE NUMBER

TOWN OR CITY AT WORK STATE ZIP CODE WORK FAX NUMBER

COMPANY'S WEBSITE ADDRESS (U.R.L.) (if any) YOUR OFFICE E-MAIL ADDRESS (at your company)

Also, if YOU PERSONALLY do NOT own the health care policy which covers you, we need to know WHO DOES own that policy (e.g. spouse); this person / policy is the "Guarantor".

Policy owner OTHER THAN you, the patient:

OTHER'S FULL NAME: FIRST, MID. INIT., LAST OTHER'S SOCIAL SECURITY #.

OTHER'S FULL ADDRESS (STREET, CITY, STATE, ZIP) OTHER'S HOME PHONE NUMBER

NAME of OTHER'S EMPLOYER FULL-TIME PART-TIME

OTHER'S RELATION TO YOU / the PATIENT OTHER'S AGE Other's BIRTH DATE: MM - DD - YYYY

Name of person who referred you to us: _____

Or, where you had learned about us: _____

Please **TURN sheet OVER** and complete OTHER SIDE TOO-->

Doctor – Patient Agreements

Dr.Ken's Wethersfield Podiatry & Foot Health Services in Wethersfield, Connecticut

- **I give permission to Dr. Sokolowski to examine and treat me** (or, if applicable, my child or ward) according to his best judgment in consultation with me.
- **I understand that Dr. Sokolowski's providing care for me is contingent upon my cooperation with him.** Information which I have provided him and will provide him, as he requests it (for purposes of the evaluation and management of my health care) is and shall be honest, accurate, complete and not withheld. Failure in these duties of mine shall be grounds for termination of our doctor-patient relationship.
- Regarding insurance plans and their non-payments, **I understand that I have a duty to promptly pay for all financial charges for non-covered and/or out-of-plan services and items** provided to me (or ward), and I will. I will not delay payment for these items; it is my duty to question my insurance plan(s) about any non-covered and/or out-of-plan services and their non-payment for them, not the doctor's. Failure to pay these charges on the date of service, except as arranged otherwise, shall incur charges for delinquent payments, account maintenance and, if needed, collection services including legal fees.
- **I understand that it is my duty to know the full extent of my own health insurance coverage(s)** and, thus, I release Dr. Sokolowski from all obligations to additionally inform me of what may or may not be non-covered services and items under the terms of those plans. It is my own duty to obtain from my primary MD provider any "authorization" for care to be received here (before seeking that care) as may be required by my restricted-access HMO or other "gate-keeper" type of medical care organization.
- **So that insurance claims may be processed promptly, I give Dr. Sokolowski my permission to submit necessary claims for me**, without having to additionally obtain my signature each time services or items are provided to/for me. My signature below shall constitute an "on file" copy for purposes of filing claims as the need arises for my benefit. I authorize that the resulting benefits' payments be made directly to the doctor for services rendered or items provided for me.
- Dr. Sokolowski will submit to my secondary or tertiary insurance plans only when he participates in one or both of those plans. (Ordinarily, the doctor submits claims to a primary plan only.) **I understand that it will be my own duty to submit to my secondary or other insurance plans, in which Dr. Sokolowski may not participate**, so that I may receive reimbursement for payments I have already made to him. Should an overpayment to the doctor result, a prompt refund to the source of that overpayment will be made, to me/patient or insuring entity as the case may be.
- **I give Dr. Sokolowski my permission to consult and/or exchange information with and to receive pertinent information from my other physicians and health care providers**, as often as the need arises, so that I may benefit from such health care coordination. A signed copy of this form shall satisfy any requirements my other providers have to release this information.
- On the reverse side of this sheet is a **federally required HIPAA form which I must sign** acknowledging that I have been given the opportunity to review Dr. Sokolowski's Privacy Policy, which outlines what this practice is doing and must do to protect my privileged, private health information. If I have signed this form for this practice previously I understand that I do not need to sign it again, per current rules.
- I give Dr. Sokolowski permission to release to my health insurance plans, carriers or companies or their agents, any information he may have which they may require to **determine the validity of those claims submitted for my benefit.**

SIGNATURE of ADULT PATIENT or the RESPONSIBLE ADULT
for a MINOR CHILD, CHARGE OR WARD of that ADULT

Today's DATE : (MM / DD / YYYY)
(form-np3-consent-070629.doc)