Yurkanin
FOOT & ANKLE RECONSTRUCTIVE CENTER

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NEW PATIENT REGISTRATION
INFORMACIÓN DE PACIENTE

Your Primary Doctor/Médico de cabecera _____

Referred by/¿Quién lo refirió? _____/ Google

Name (First, Last)/Nombre, Apellido _____

Birthdate/Fecha de nacimiento _____ SS # _____

Sex/Sexo: **Male,** Masculino / **Female**, Femenina / **Other**

Marital status/Estado civil: **Single,** Soltero / **Married,** Casado / **Divorced**, Divorciado / **Widowed,** Viudo

Home address/Domicilio _____

City/Ciudad _____ **State**/Estado _____**Zip**/Código Postal _____

Mobile/celular #_____ **Alternative**/numero alternativo #_____

Email/Correo electrónico _____

☐ **Please check this box if you agree to receive automated text, voice messages and/or email to the provided information. We use this to send you important updates about the office, your appointment and offer promotions. We do not spam.** / Por favor de seleccionar esta opción si acepta recibir texto automatizado, mensajes de voz y correo electrónico. *Usamos esta información para enviarle actualizaciones importantes sobre la oficina, su cita, y ofrecer promociones.*

Occupation/Ocupación: _____**Employer**/Empleador: _____

If patient is a minor (under age 18), parent or guardian to fill out
Si el paciente es menor de (18 años), favor de completar por los padres o guardianes

Parent or Guardian Name/Nombre de un pariente o amigo local _____

Relationship to the patient/Relación al paciente _____

Primary #/Número de teléfono (casa) _____

Secondary #/Número de Teléfono (celular) _____

EMERGENCY CONTACT
EN CASO DE EMERGENCIA

Name/Nombre _____

Relationship to the patient/Relación al paciente _____

Primary #/Número de teléfono (casa) _____

Secondary #/Número de Teléfono (celular) _____

Do you authorize us to discuss your health information with this person? _____**YES** *Si* _____**NO** *No*
Nos autoriza a discutir su información de salud con esta persona?

COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ **Date of Birth:**_____

What is your specific foot/ankle problem?

_____

_____

When did this begin? _____

The problem is: □ Improving □ Worsening □ Unchanged

Onset: □ Sudden □ Gradual **What makes it worse?** _____

What makes it better? _____

Does it hurt? □ Yes □ No **Duration:** □ Constant □ Every now and then

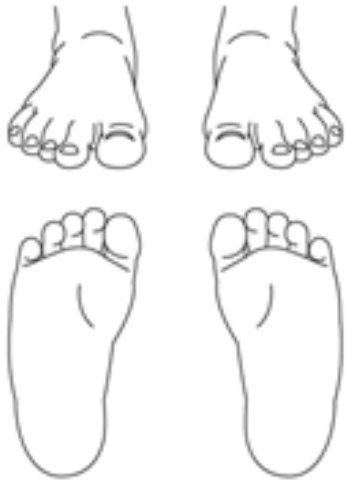
Rate the pain level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worse pain)

Describe the pain: □ Sharp □ Dull □ Achy □ Burning □ Shooting □ Clicking □ Cramping

□ Itching □ Other _____

Describe previous treatment: _____or □ None

Is this from an injury? □ Yes □ No **Is it work-related?** □ Yes □ No



REVIEW OF SYSTEMS (Circle if you **currently** experience any of the following):

Constitutional sudden weight loss or weight gain, fever, fatigue
Head headache, dizziness, vision changes
Cardiovascular cold feet, night cramps, pain in calves when walking, pain in legs at rest, chest pain, swelling in legs
Respiratory cough, difficulty breathing
Musculoskeletal joint pain or aches, low back problems, weakness
Neurological shooting or burning pain, numbness, tingling
Psych depression, suicidal thoughts, forgetfulness, dementia, mood swings
Gastrointestinal nausea, vomiting, upset stomach, indigestion
Skin rashes, dry skin, itchiness, open sores, toenail fungus, nail changes, callus, plantar warts

Pharmacy Name: _____Address_____

PAST MEDICAL HISTORY (Circle if you have/had):

AIDS / HIV	Bleeding, clot disorder	Gout	Kidney problems
Arthritis	Cancer	Headaches/migraines	Liver disease
Anemia	Chest pain	Hepatitis A / B / C	Neuropathy
Artificial heart valve/heart disease	Circulation problems	High or low blood pressure	Psychiatric care
Asthma or shortness of breath	Diabetes Type 1	Sexually transmitted disease (STD)	Stroke
Back problems	Diabetes Type 2	Stomach ulcers	Tuberculosis
	Epilepsy/seizure		Other:
	Eye problems		

HOSPITALIZATIONS / SURGICAL HISTORY:

_____

_____

_____

FAMILY MEDICAL HISTORY

Mother _____

Father _____

Siblings _____

SOCIAL HISTORY

I live with ☐ no one ☐ spouse ☐ children ☐ parents ☐ other

I stand ____ % of my day I exercise, per week: ☐ 0 days ☐ 1-2 days ☐ 3+ days

List sports/activities _____

Tobacco or nicotine use, # of years _____Recreational drug use _____

Former smoker quit date _____Alcohol use (# drinks/week) _____

ALLERGIES (circle): Codeine Contrast dye Latex Penicillin Sulfa Shellfish

Other: _____

MEDICATION List of medication, herbal supplement (or provide a copy of your list) with dosage and frequency.

_____

_____

_____

STATS

Age _____ Height _____ Wt _____ Shoe Size _____ *For Office Staff: T ____BP _____ P ____ BMI _____*