DR. STUART FELDMAN

Fall Risk Assessment Tool

If patient has any of the following conditions, check the box and apply Fall Risk interventions as indicated.

High Fall Risk - Implement High Fall Risk interventions per protocol

- ☐ History of more than one fall within 6 months before admission
- ☐ Patient has experienced a fall during this hospitalization
- ☐ Patient is deemed high fall-risk per protocol (e.g., seizure precautions)

Low Fall Risk - Implement Low Fall Risk interventions per protocol

- ☐ Complete paralysis or completely immobilized

Do not continue with Fall Risk Score Calculation if any of the above conditions are checked.

FALL RISK SCORE CALCULATION – Select the appropriate option in each category. Add all points to calculate Fall Risk Score. (If no option is selected, score for category is 0)	**Points**
Age ***(single-select)*** ☐ 60 - 69 years (1 point) ☐ 70 -79 years (2 points) ☐ Greater than or equal to 80 years (3 points)	
Fall History ***(single-select)*** ☐ One fall within 6 months before admission (5 points)	
Elimination, Bowel and Urine ***(single-select)*** ☐ Incontinence (2 points) Urgency or ☐ frequency (2 points) Urgency/frequency ☐ and incontinence (4 points)	
Medications: Includes PCA/opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropics ***(single-select)*** ☐ On 1 high fall risk drug (3 points) On 2 or ☐ more high fall risk drugs (5 points) Sedated ☐ procedure within past 24 hours (7 points)	
Patient Care Equipment: **Any equipment that tethers patient (e.g., IV infusion, chest tube, indwelling catheter, SCDs, etc.)** ***(single-select)*** ☐ One present (1 point) ☐ Two present (2 points) ☐ 3 or more present (3 points)	
Mobility ***(multi-select; choose all that apply and add points together)*** ☐ Requires assistance or supervision for mobility, transfer, or ambulation (2 points) ☐ Unsteady gait (2 points) ☐ Visual or auditory impairment affecting mobility (2 points)	
Cognition ***(multi-select; choose all that apply and add points together)*** ☐ Altered awareness of immediate physical environment (1 point) ☐ Impulsive (2 points) ☐ Lack of understanding of one's physical and cognitive limitations (4 points)	
Total Fall Risk Score (Sum of all points per category)	
SCORING: 6-13 Total Points = Moderate Fall Risk, >13 Total Points = High Fall Risk	

(702) 407-2548 lori@stuartfeldmandpm.com 8955 S Pecos Rd, Suite 2B, Henderson, NV 89074

DR. STUART FELDMAN

Peripheral Arterial Disease (PAD) Questionnaire

Today's Date	Day:	Month:	Year:
Patient Initials	First:	Middle:	Last:
	Age (yrs.)	Gender: ☐ Male ☐ Female	

Answers to the following questions will help determine if you are at risk for PAD and if a vascular examination can help better assess your vascular health status.

Do you experience any pain in your legs or feet while at rest? ☐ Yes ☐ No

Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise? ☐ Yes ☐ No

If Yes to Question 2, does the pain go away when you stop walking/exercising? ☐ Yes ☐ No

Do your feet get pale, discolored or bluish at any time during the day? ☐ Yes ☐ No

Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks? ☐ Yes ☐ No

Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication? ☐ Yes ☐ No

Do you have high blood pressure or take medication to reduce blood pressure? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you have a history of chronic kidney disease? ☐ Yes ☐ No

Do you currently or have you ever smoked? ☐ Yes ☐ No

Do you have a history of stroke or mini-stroke (TIA)? ☐ Yes ☐ No

Do you have a history of heart disease (heart attack, MI)? ☐ Yes ☐ No

Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm), and/or stent placement? ☐ Yes ☐ No

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DR. STUART FELDMAN

Practice: _____ Todays Date: _____

Name: _____ DOB: _____ Chart Number: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

Emergency Name: _____ Phone: _____

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

Home#: _____ Cell#: _____ Other#: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the Insured: ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relation to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone#: _____ Sex: ☐ Male ☐ Female DOB: _____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the Insured: ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relation to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Phone#: _____ Sex: ☐ Male ☐ Female DOB: _____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone Book ☐ Family member

☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

Result of accident or work injury? ☐ Yes ☐ No

How long has this bothered you? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

What treatment have you tried & have they been affected? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____ /10

The pain quality is: ☐ Burning ☐ Constant ☐ Dull ☐ Sharp ☐ Shooting

☐ Throbbing ☐ Tingling ☐ Other: _____

PLEASE READ AND SIGN:

The above is information is correct to the best of my knowledge, I understand that throughout my treatment, I am responsible for the notifying the physician and/or medical of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

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DR. STUART FELDMAN

Practice: _____ Todays Date: _____

Name: _____ Chart #: _____ Date of birth: _____

Ethnicity: ◻ Hispanic or Latino ◻ Not Hispanic or Latino ◻ Declined to specify

Race: ◻ Asian ◻ American Indian or Alaska Native ◻ Black or African American

◻ White ◻ Native Hawaiian or ocher Pacific Islander ◻ Declined co specify

◻ Declined co specify

Preferred Language: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ◻ Yes ◻ No Can we send mail to the address on file? ◻ Yes ◻ No

Can we call the phone number on file? ◻ Yes ◻ No Can we leave voicemail on machine? ◻ Yes ◻ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ◻ Yes ◻ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ◻ Wife ◻ Husband ◻ Daughter ◻ Son ◻ Other: _____

Name(s): _____

Smoking Status

◻ Current Every Day ◻ Smoker, Current Status Unknown

◻ Current Some Day ◻ Heavy Tobacco ◻ Unknown If Ever

◻ Former ◻ Never ◻ Light Tobacco ◻ Decline to answer

Vital Signs

Blood Pressure _____ / _____

Height: _____ Weight: _____

Current Medications

◻ No Known Medications ◻ I take the following medications:

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Use the back of this form if more room is needed

Allergies

◻ No Known Allergies ◻ No Known Drug Allergies

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Name/ Dose: _____

Last Flu Shot Date: _____ Did you get a pneumococcal vaccination? ◻ Yes ◻ No

Have you fallen in the last 12 months? ◻ Yes ◻ No Were you injured from the fall? ◻ Yes ◻ No

Advanced Directives: ◻ Living Will ◻ DNR ◻ Durable Power of Attorney ◻ Surrogate Appointed ◻ None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

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DR. STUART FELDMAN

History and Physical

Name: _____ Chart #: _____ Date of birth: _____

Medical History:

□ Alcoholism □ Blood disorders □ Circulation problems □ Musculoskeletal □ Breathing issues
□ Liver □ Sleep apnea □ Gout □ Allergies □ Heart disease □ Asthma
□ Heart murmur □ Stomach/bowel □ Depression □ Anxiety disorder □ Mental illness □ Kidney disease
□ Blood clot □ Cancer □ Hepatitis □ High cholesterol □ High blood pressure
□ Neuropathy (specify) _____ □ Thyroid disease (specify) _____
□ Diabetes (type 1, type 2) _____ □ Arthritis (specify) _____ □ HIV □ CVA
□ Skin disorders □ Stroke □ Other (specify) _____
Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

Surgical History □ None □ Appendectomy □ C-Section □ Angioplasty □ Bypass □ Cataracts □ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? □ Yes □ No
If yes, please describe: _____
Do you have any artificial joints? □ Yes (where? _____) No Do you have an artificial heart valve? □ Yes □ No

Social History Do you smoke? □ Yes □ No If yes how many packs per day? □ 1 □ 2 □ 3 □ 4 □ 5 For how long? _____
Do you drink alcohol? □ Yes, everyday (5-7 days/week) □ Yes, occasionally/socially □ No/Rarely
Substance abuse: □ Yes, I have a current substance abuse problem. Please specify: _____
□ Yes, I had a past substance abuse problem. Please specify: _____
□ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly □ standing or Do □ sitting
you exercise regularly? □ No, I do not exercise regularly □ Yes, I do the following regular exercise: _____

Family History Is there any family history (blood relative) of: (Please indicate family member)

□ Alzheimer's _____ □ Depression _____ □ Arthritis _____
□ Diabetes _____ □ Bleeding disorders _____ □ Emphysema _____
□ Blood clot _____ □ Heart disease _____ □ Cancer _____
□ High Blood Pressure _____ □ Cataracts _____ □ Neurological _____
□ Circulation problems _____ □ Strokes _____ □ Other (specify): _____

Review of Systems

Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	□ leg pain when walking □ fainting	□ fever □ palpitations	□ chest pain/pressure □ vascular disease	□ leg swelling □ valve problems	□ cold hands/feet □ NONE	
Genitourinary	□ blood in urine □ decreased frequency	□ hesitancy □ excessive urination	□ incontinence □ kidney disease	□ increased urgency □ kidney stones	□ NONE	
Gastrointestinal	□ abdominal pain □ diarrhea	□ heartburn □ trouble swallowing	□ blood in stool □ decrease appetite	□ vomiting □ increase appetite	□ ulcers □ constipation □ NONE	
Integumentary	□ athletes foot	□ nail abnormalities	□ keloids	□ itchiness	□ dry, scaly skin	□ NONE
Hematologic	□ lower leg ulcers	□ sickle cell disease	□ anemia	□ blood thinners	□ clotting disorders	□ NONE
Neurological	□ tingling □ tremors	□ weakness □ paralysis	□ seizures □ NONE	□ numbness	□ headaches	
Musculoskeletal	□ back pain □ sciatica	□ joint swelling □ joint stiffness	□ muscle weakness □ joint pain	□ muscle pain □ joint instability	□ neck pain □ arthritis	□ NONE
Respiratory	□ chest pain □ shortness of breath	□ wheezing	□ COPD □ emphysema	□ coughing □ NONE	□ snoring	

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

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STUART M. FELDMAN, D.P.M., A.P.C.

Medical & Surgical Treatment of the Foot
Main Office: 8955 S. Pecos Rd., Suite 2B Henderson, NV 89074
Phone: 702-407-2548 / Fax: 702-407-2549

MEDICARE, MEDICAID & PRIVATE INSURANCE DEDUCTIBLE NOTICE 01/01/2026-12/31/2026

Please consider this signed/ dated acknowledgement to be my promise to pay for any charges that are incurred from treatment by Stuart M. Feldman, D.P.M., A.P.C. if my yearly deductible has not been met (paid) or treatment is NOT covered by my insurance.

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____

PODIATRY TREATMENT WAIVER

Date: _____

I _____ have been advised that if I receive podiatry and/or wound care treatment by Dr. Stuart M. Feldman that my insurance carrier may only allow a percentage or may make partial payment. I understand that I may have a coinsurance amount that will be owed to Dr. Stuart M. Feldman for these services.

I understand that my insurance plan may have a deductible that must be satisfied before they make any payments. I also understand that Dr. Feldman's contracts with insurance plans make it illegal to waive patient deductibles and co-pays.

Our office is unable to determine the exact reimbursement of an item, as each insurance carrier contracts differently. After an insurance company issues an explanation of benefits (EOB), we will be able to determine the patient's responsibility.

I authorize Dr. Stuart Feldman, podiatrist, to treat me for any podiatric condition including wounds, infections, ingrown nails and trimming of nails, corns and calluses and any other foot related conditions that Dr. Feldman opines is medically necessary.

_____ _____

Signature Date

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STUART M. FELDMAN, D.P.M., A.P.C.

Medical & Surgical Treatment of the Foot

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To obtain more formation about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy rule Section 164.52()(2)(ii), you may contact the Practice's privacy officer:

Lori Feldman
P.O.Box 33729
Las Vegas, NV 89133
702-407-2548

Practice's Requirements

The Practice

a. I required by federal law to maintain the privacy of your PHI and to provide you with the Privacy Notice Detailing the Practice's legal duties and privacy practices with respect to your PHI.

b. Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided under federal Law.

c. Is required to abide by the terms of this Privacy Notice.

d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

e. Will distribute any revised Privacy Notice to you prior to implementation.

f. Will not retaliate against you for filing a complaint.

Effective Date

This notice is effective as of January 1, 2026.

Patient Acknowledgment

By signing my name below, I acknowledge a receipt of a copy of this Notice, (if requested) and my understanding and my agreement to its terms.

Patient's Signature _____ Date _____