



# NORTHWEST FOOT & ANKLE SPECIALISTS

*Personalized Professional Total Foot & Ankle Care*

Dr. Gordon S. Nishimoto

Dr. Bryan L. Berghout

### NATURE OF COMPLAINTS (Please Print)

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR VISIT (Please Complete): \_\_\_\_\_

Please Rate your pain 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_

IF INJURED, DATE: \_\_\_\_\_ PLACE:  HOME  SCHOOL  WORK  AUTO  OTHER

IF WORK INJURY, IS THE CLAIM OPEN?  YES  NO CLAIM# \_\_\_\_\_

CLAIM MANAGER \_\_\_\_\_ PHONE # \_\_\_\_\_

### PERSONAL MEDICAL HISTORY – CHECK BOX IF APPLIES THEN CIRCLE CONDITIONS

**GENERAL:**

- \_\_\_ weight gain or loss, change
- \_\_\_ appetite change activity
- \_\_\_ change in energy level

**NEUROLOGICAL:**

- \_\_\_ weakness
- \_\_\_ muscle spasms
- \_\_\_ numb feet
- \_\_\_ chronic pain,
- \_\_\_ epilepsy, seizures

**PSYCHIATRIC:**

- \_\_\_ depression
- \_\_\_ Bipolar
- \_\_\_ mood swings

**EYES:**

- \_\_\_ glasses
- \_\_\_ contacts

**CARDIAC:**

- \_\_\_ high blood pressure
- \_\_\_ low blood pressure
- \_\_\_ heart attack
- \_\_\_ irregular heart beat
- \_\_\_ stroke
- \_\_\_ rheumatic fever

**RESPIRATORY:**

- \_\_\_ asthma

**URINARY SYSTEM:**

- \_\_\_ kidney disease
- \_\_\_ burning with urination

**GASTROINTESTINAL:**

- \_\_\_ liver disease
- \_\_\_ alcoholism
- \_\_\_ stomach ulcers
- \_\_\_ GERD
- \_\_\_ acid reflux
- \_\_\_ bloody or black stool

**MUSCULOSKELETAL:**

- \_\_\_ muscle cramps
- \_\_\_ knee pain
- \_\_\_ unequal leg length
- \_\_\_ weak ankles
- \_\_\_ bunions, muscle pain
- \_\_\_ joint stiffness or swelling
- \_\_\_ back problems
- \_\_\_ arthritis
- \_\_\_ gout
- \_\_\_ osteoporosis

**ENDOCRINE:**

- \_\_\_ diabetes
- \_\_\_ thyroid disease
- \_\_\_ high cholesterol

**BLOOD:**

- \_\_\_ anemia
- \_\_\_ easy bruising
- \_\_\_ bleeding problems
- \_\_\_ drug abuse
- \_\_\_ HIV exposure

**VASCULAR:**

- \_\_\_ poor circulation
- \_\_\_ leg cramps
- \_\_\_ varicose veins

**ALLERGIES:**

- \_\_\_ latex sensitivity
- \_\_\_ metal sensitivity
- \_\_\_ history of anaphylaxis

**SKIN / BODY:**

- \_\_\_ rashes
- \_\_\_ non-healing lesions/sores
- \_\_\_ psoriasis
- \_\_\_ recent bug bites
- \_\_\_ tumor, abnormal growth
- \_\_\_ skin ulcers
- \_\_\_ toenail problems
- \_\_\_ cancer

**OTHER:** \_\_\_\_\_

**SURGICAL HISTORY**

Please list all surgeries previously done	Which side?	Year	Physician
1.			
2.			
3.			
4.			
5.			

Risk Factors

Name \_\_\_\_\_

1. Ever Smoked?  Yes  No  
 Packs per day \_\_\_\_\_ Year started \_\_\_\_\_  
 Date quit \_\_\_\_\_
2. Drug Use \_\_\_\_\_
3. Alcohol Use: # of drinks per day \_\_\_\_\_
4. Exercise: Frequency/week and type \_\_\_\_\_
5. Date of last Tetanus shot \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Do you take medication  Yes  No

PRESCRIPTION MEDICATION (current and dosage)

Name of Medication	Dosage	How Taken (one/two times a day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

**ALLERGIES**

No known drug Allergies

MEDICATIONS(S) you are ALLERGIC to:

REACTION to that Mediation:

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |

FAMILY HISTORY (Please complete)

Adopted

Please state if your relatives listed below have or have had any of the following: Cancer, Heart trouble, Kidney Disease, Stroke, Arthritis, Diabetes, High Blood Pressure, Tuberculosis, Emphysema, Foot problems.

Mother/Father etc. & Health Problems	Age if living	Age if deceased	Cause of Death

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# NORTHWEST FOOT & ANKLE SPECIALISTS

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425-337-7000 feetnw@hotmail.com

## THE STAFF WELCOMES YOU TO OUR OFFICE

Name _____ Today's Date: _____		
Last Name	First Name	Initial
What name do you wish us to call you by? _____		Social Security # _____
Address: _____		Apt # _____ Home Phone: ( ) _____
City _____	State _____	Zip _____ Cell Phone: ( ) _____
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ Birth date: _____ Email: _____		
Patient Employed by: _____		Work Phone: _____
Amount of your insurance copay: _____		Does your insurance require a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Physician: _____		Previous Podiatrist: _____
Whom may we thank for referring you? <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Friend _____ <input type="checkbox"/> Other _____		
In case of emergency who should be notified? _____		Phone: ( ) _____
What is your foot and ankle concern? _____		

Primary Insurance Company _____	
Group # _____	Policy/Subscriber # _____
Policy Holder Name _____	Date of Birth _____
Policy Holder Address _____	Social Security# _____
Subscriber Employer _____	Work Phone _____
Relationship to patient _____	Policy Effective Date _____

Secondary Insurance Company _____	
Group # _____	Policy/Subscriber # _____
Policy Holder Name _____	Date of Birth _____
Policy Holder Address _____	Social Security# _____
Subscriber Employer _____	Work Phone _____
Relationship to patient _____	Policy Effective Date _____

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage as listed about and assign directly Northwest Foot & Ankle Specialists all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date