Austin Podiatry House Calls
HAPPY FEET AT HOME

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PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS		
Patient Name:		
Gender at birth:	☐ Male ☐ Female	**SSN:**
Patient's Date of Birth:		
Street Address:		
City:		
State:		
Zip Code (+4):		
Home Number:	☐ Main Phone Number	
Cell Phone Number:	☐ Main Phone Number	
Family Contact #: (optional)		
Are texts OK?	☐ YES	☐ NO
Email Address:		
Typical wake up time:		
CARE TEAM DETAILS		
Referring Source Name:		
On Hospice Care? (If yes kindly indicate the Hospice Care Name)		
Primary Physician Name:		

Primary Physician Contact #:	
Primary Physician Last Visit Date: **(Month/Day/Year)**	**(Insurances require an exact date within the last 6 months for nail and callus coverage. We are unable to schedule an appointment without this information.)**
Preferred Pharmacy:	
Preferred Pharmacy Contact #:	
INSURANCE DETAILS	
Primary Insurance Name:	
● Member ID #:	
● Group ID #:	
Secondary Insurance Name:	
● Member ID #:	
● Group ID #:	
MEDICAL HISTORY	
What foot conditions would you like treated?	
Medical Conditions:	
Medications:	
Food and Drug Allergies:	
Family History (What medical conditions have others in your family dealt with?):	☐ Mother ☐ Father ☐ Grandparent ☐ Sister ☐ Brother ☐ Son ☐ Daughter ☐ Other _____

Social History ● Are you married?	☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
● Do you smoke?	☐ Yes ☐ No ☐ If previous, quit_____years ago
● Do you exercise? If so, how often?	☐ No ☐ A little ☐ Moderate ☐ More than most
● Special Diet?	☐ No ☐ Regular ☐ Diabetic ☐ Low salt ☐ Low Carb ☐ Gluten Free ☐ Other _____
● Do you use any devices to walk?	☐ No ☐ Walker ☐ Cane ☐ Wheelchair
Surgical History	
Ethnicity (optional):	
Language:	☐ English ☐ Spanish ☐ Other

REVIEW OF SYMPTOMS

Please list any of your issues with the following body symptoms:

● **Constitutional symptoms** (fatigue, appetite & weight changes)	
● **Eyes** (blurry vision, eye problems)	

● **Ears, nose, mouth, throat** (hearing loss, ear pain, nose/mouth/throat problems)	
● **Cardiovascular** (chest pains, rapid heart rate, palpitations)	
● **Respiratory** (shortness of breath, wheezing,cough)	
● **Gastrointestinal** (stomach/intestinal pain, constipation,nausea, vomiting, heartburn)	
● **Genitourinary** (increased frequency, incontinence, urgency, pain)	
● **Musculoskeletal** (joint pains, stiffness, arthritis, swelling, weakness)	
● **Integumentary** (skin rashes, lesions, dryness)	
● **Neurological** (numbness, burning, tingling, paralysis, drop foot)	
● **Psychiatric** (anxiety, depression, dementia, agitation, memory loss)	
● **Endocrine** (ex: thirst, sugar imbalances, temperature intolerance)	
● **Hematologic/Lymphatic** (blood thinners, clotting issues, bleeding, bruising)	
● **Allergic** (hay fever, skin reactions, runny nose)	