Please answer the following: ***Email your completed form(s) to lincolnfootclinic@gmail.com***

Have You Had or Do You Have:	Yes	No		Yes	No
Respiratory			**Muscular/Skeletal**		
Sleep Apnea and/or Snoring			Hammertoes		
Asthma			Bunions		
Bronchitis			Heel Spurs		
Chronic Cough			Flat Feet		
Shortness of Breath			Bone Spurs		
Tuberculosis and/or Emphysema			Arthritis		
Any Other Lung Trouble:			Muscular Dystrophy		
Cadiac			Scoliosis		
High Blood Pressure			Gout		
Stroke			**Dermatology**		
Heart Attack			Fungus Nails		
Chest Pain			Callouses		
Irregular Beat/Arrhythmia			Warts		
Congestive Heart Failure			Scleroderma		
Pacemaker			Psoriasis		
Endocrine					
Hepatitis			**Eyes, Ears, Nose, Throat (EENT)**		
Liver Trouble (please specify)			Macular Degeneration		
Diabetes – Insulin/Oral Meds/Diet			Blindness		
Kidney Trouble (please specify)			Glaucoma		
Thyroid Problems			Cataracts		
Gastrointestinal			Glasses and/or Contacts		
Hiatal Hernia			Hearing Loss and/or Hearing Aids		
Stomach Ulcers			Tinnitis		
Neurological			Frequent Nose Bleeds		
Epilepsy/Seizures			Frequent Sore Throats		
Paralysis, Numbness, Tingling in Extremities			Difficulty Swallowing		
Spinal Stenosis			Acid Reflux		
MS					
Vascular			**Social History**		
Blood Clots			Do you smoke? # Packs Per Day		
Phlebitis			Alcohol Use		
Poor Circulation			**Other**		
Varicose Veins			Are you pregnant?		
Leg and/or Foot Ulcers			Cancer: Type _____		
Chronic Foot and/or Leg Swelling					
Anemia					

Please explain or list any illnesses not mentioned above:

_____

_____

_____

Allergies: (Include all – not just drug related) _____

Please list previous operations and any complications:

_____

_____

_____

Have you or a family member had an unusual reaction to anesthesia, sedative or narcotic medication?

Yes _____ No _____ Comments: _____
(eg: nausea, vomiting, severe allergic reaction, difficulty awakening from anesthesia)

Have you ever had to take Cortisone or Prednisone? Yes _____ No _____ When: _____

Do you take or have you ever taken Coumadin or other blood thinners? Yes _____ No _____

One Time Authorization:

I Request That Payment of Authorized Insurance Benefits (Medicare or Private) Be Made Either To Me Or On My Behalf To Dr. James/Dr. Hahne For Any Services Furnished Me By Said Doctor. I Authorize Any Holder Of Medical Information Administration And It's Agents, Or To My Private Insurance, Any Information Needed To Determine These Benefits Or The Benefits Payable For Related Services.

I Have Been Notified By Dr. Fred M. James That Routine Foot Care Is Not Covered By Medicare. I Agree To Be Personally And Fully Responsible For Services Considered Routine Foot Care.

Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

I Acknowledge That I Was Provided A Copy Of The Notice Of Privacy Practices And That I Have Read (Or Had The Opportunity To Read If I So Chose) And Understood The Notice.

Cancellation of Appointment

If Unable To Keep Your Appointment, A 24-Hour Prior Notice Must Be Given, Or You May Be Subject To A Charge For Your Time Slot.

_____ _____

Patient Name (Please Print) Date

_____

Signature

Email your completed form(s) to lincolnfootclinic@gmail.com