BROWN MEDICINE
BROWN PHYSICIANS, INC.

Division of Podiatry

Patient Intake Form

Patient Name (Print): _____ Date of birth: _____

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? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective?

_____

On a scale from 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: _____

Are you a diabetic? ☐ Yes ☐ No If yes, when was your last retinal exam? _____

Who is your Ophthalmologist? _____

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

☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or other Pacific Islander

Preferred Language: _____

What is your current gender identity? (Circle all that apply)

Male Female Transgender-Male Transgender-Female Genderqueer Decline to answer

What sex were you assigned at birth? Male Female Decline to answer

Which pronouns do you use? _____

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 a voicemail to the number on file? ☐ Yes ☐ No

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

_____ Initials _____ Date

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History of Drug Allergy: ☐ **NONE**

Name of Medication	Date of adverse reaction	Symptoms

Current Medications: ☐ **NONE**

Name of Medication	Dose	Notes

Surgical History

☐ None ☐ Appendectomy ☐ C-section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle anywhere on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints? ☐ Yes If yes, where? _____

Do you have an artificial valve? ☐ Yes ☐ No

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Review of Systems (Please check the box if you currently have any of the following symptoms or check **NONE**)

Cardiovascular ☐leg pain when walking ☐fever ☐chest pain/pressure ☐leg swelling ☐cold hands/feet ☐fainting ☐palpitations ☐vascular disease ☐valve problems ☐**NONE**

Genitourinary ☐blood in urine ☐hesitancy ☐incontinence ☐increased urgency ☐decreased frequency ☐ excessive urination ☐kidney disease ☐kidney stones ☐**NONE**

Gastrointestinal ☐abdominal pain ☐heartburn ☐blood in stool ☐vomiting ☐ulcers ☐constipation ☐diarrhea ☐trouble swallowing ☐decrease appetite ☐increase appetite ☐**NONE**

Integumentary ☐athlete's foot ☐nail abnormalities ☐keloids ☐itchiness ☐dry, scaly skin ☐**NONE**

Hematologic ☐lower leg ulcers ☐sickle cell disease ☐anemia ☐blood thinners ☐clotting disorder ☐ **NONE**

Neurological ☐tingling ☐weakness ☐seizures ☐numbness ☐headaches ☐tremors ☐paralysis ☐**NONE**

Musculoskeletal ☐back pain ☐joint swelling ☐muscle weakness ☐muscle pain ☐neck pain ☐sciatica ☐joint stiffness ☐joint pain ☐joint stability ☐arthritis ☐**NONE**

Respiratory ☐chest pain ☐wheezing ☐COPD ☐coughing ☐snoring ☐shortness of breath ☐emphysema ☐**NONE**

Medical History ☐Alcoholism ☐Blood disorders ☐Circulation problems ☐Liver ☐Sleep apnea ☐Gout ☐Allergies ☐Blood clot ☐High cholesterol ☐High Blood pressure

☐Neuropathy (specify) _____ ☐Thyroid disease (specify) _____

☐ Arthritis (specify) _____ ☐Other (specify) _____

☐Musculoskeletal ☐Breathing issues ☐Heart disease ☐Asthma ☐Mental illness ☐Kidney disease ☐Hepatitis ☐Diabetes (type I or II) ☐HIV ☐CVA Skin Disorders ☐Stroke ☐Cancer ☐Depression ☐Anxiety disorder ☐Heart Murmur ☐Stomach / bowel

Are you pregnant? ☐Yes ☐No **Are you nursing?** ☐Yes ☐No

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Family History

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

- ☐ Alzheimer's _____
- ☐ Arthritis _____
- ☐ Bleeding _____
- ☐ Blood clot _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Circulation problems _____
- ☐ Other (specify) _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Emphysema _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Neurological _____
- ☐ Strokes _____

Social History

Do you smoke? ☐ Yes ☐ No ☐ **Decline to answer** If yes, how many packs per day? _____ For how long? _____

Do you drink alcohol? ☐ Yes, everyday (5-7 days a week) ☐ Yes, socially/ occasionally ☐ No

☐ **Decline to answer**

Do you have a substance abuse problem? ☐ Yes ☐ No ☐ **Decline to answer** If yes, please specify which substances you are abusing: _____

What is your occupation? _____

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise:

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**

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 updates to the information listed below.

Patient (or Legal Guardian) Signature: _____

_____Initials _____ Date