**Big Sky Foot & Ankle Institute, Inc.**

Today's Date ____________________

# PATIENT INTAKE FORM

Patient ID: __________

Patient Name: ____________________

Date of Birth: ____________________ Social Security Number: ____________________

Address: ____________________

City, State, Zip Code: ____________________

Home Number: ____________________ Work Number: ____________________

Mobile Number: ____________________ Is it OK if we text you? ☐ YES ☐ NO

E-mail: ____________________ Is it OK if we E-mail you? ☐ YES ☐ NO

How would you prefer we contact you? ☐ Home Phone ☐ Mobile Phone ☐ US Postal Mail

Language: ☐ English ☐ Spanish ☐ Other ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widower ☐ Partner

Race: ☐ White ☐ Hispanic/Latino ☐ Other ____________________ ☐ Decline to Answer

Ethnicity: ____________________ ☐ Decline to Answer

Primary Physician: ____________________ Telephone Number: ____________________

Referring Physician: ____________________ Telephone Number: ____________________

Pharmacy: ____________________ Address of Pharmacy: ____________________

How did you hear about us? ____________________

Reason for your visit: ____________________

Condition Related to:
Employment ☐ YES ☐ NO Auto Accident ☐ YES ☐ NO Other Accident ☐ YES ☐ NO Another Party Responsible ☐ YES ☐ NO

Level of pain (1-10): __________ Height: __________ Weight: __________

Allergies and Reaction: ____________________

____________________

Medications: ____________________

____________________

____________________

**CONTINUE TO NEXT PAGE ON REVERSE SIDE**

## REVIEW OF SYSTEMS

Are you currently experiencing any of the following?

| | | | |
|---|---|---|---|
| Fever | ☐ YES ☐ NO | Night Sweats | ☐ YES ☐ NO |
| Shortness of Breath | ☐ YES ☐ NO | Chest Pain/Palpitations | ☐ YES ☐ NO |
| Coughing/Wheezing | ☐ YES ☐ NO | Leg Pain When Walking | ☐ YES ☐ NO |
| Muscle Aches | ☐ YES ☐ NO | Muscle Weakness | ☐ YES ☐ NO |
| Joint Pain | ☐ YES ☐ NO | Swelling of Your Extremities | ☐ YES ☐ NO |
| Skin Rashes | ☐ YES ☐ NO | Growths or Lesions | ☐ YES ☐ NO |
| Depression | ☐ YES ☐ NO | Sleep Disturbances | ☐ YES ☐ NO |

## SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO If YES, how many packs a day? ________ How long have you smoked? ________

When did you quit smoking? ____________________ Other tobacco use? ____________________

Alcohol consumption? ☐ YES ☐ NO How frequently do you consume alcohol? ____________________

Illicit drug use? ☐ YES ☐ NO Provide further information: ____________________

Occupation: ____________________

Employer: ____________________

## PAST MEDICAL HISTORY

List any other medical conditions that you have: ____________________

____________________

Do you have diabetes? ☐ YES ☐ NO Last blood sugar? ____________________ HgB A1c: ________

Do you take Insulin? ☐ YES ☐ NO Last visit with primary care provider? ____________________

## FAMILY HISTORY OF MEDICAL CONDITIONS

Father: ____________________ Deceased: ☐ YES ☐ NO

Mother: ____________________ Deceased: ☐ YES ☐ NO

Brother: ____________________ Deceased: ☐ YES ☐ NO

Sister: ____________________ Deceased: ☐ YES ☐ NO

## PAST SURGERIES

List any surgeries you have had in the last 10 years: ____________________

____________________

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**I attest that the above information is current and accurate, and it is my responsibility to notify the physician or their staff of changes to the above.**

**Signature:** ____________________ **Date:** ____________________

Signed by Guardian? ☐ YES ☐ NO Name of Guardian: ____________________

Relationship of Guardian to Patient: ____________________ Guardian Phone Number: ____________________