

# DR. SPENCE D. HARPER

*Wasatch Foot and Ankle Center*

## WELCOME TO OUR OFFICE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. If you have questions regarding our health information privacy policies, please inquire the front office for a copy of our policies.

PATIENT INFORMATION			
<b>Patient Name:</b> <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>D.O.B:</b>	<b>AGE:</b>
<b>Address:</b> <i>(Street and Apt #)</i>	<b>Social Security Number:</b>		
<i>(City, State, Zip)</i>			
<b>Preferred Phone Number:</b>	<b>Alternate Phone Number:</b>		
<b>Email Address:</b> <i>(used for appointment reminders, newsletters, billing inquiries and the Patient Portal)</i>			
<b>Occupation:</b>	<b>Employer:</b>		
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Spouses Name (if applicable):</b>			
<b>Who may we thank for the referral to our office?</b>	<b>Date of last physical exam:</b>		
<b>Is your billing address different from the one listed above?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list your billing address below		
<b>Billing Address:</b> <i>(street or PO box, city, state, zip)</i>			

CONTACT IN CASE OF EMERGENCY		
Name:	Relationship:	Phone Number:

RESPONSIBLE PARTY <i>(if patient is a minor or under another's care)</i>		
Name:	Relationship:	DOB:
Phone Number:	Social Security Number:	

INSURANCE INFORMATION		
Is the patient the primary subscriber to this insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, what is the subscribers first and last name, date of birth, and policy number (if different from the patients' policy number)?</i>		
<b>Subscriber Name:</b>	<b>DOB:</b> ___/___/___	<b>Policy Number:</b>
<b>How is the patient related to the subscriber?</b>		

<b>Primary Insurance Company:</b> <i>(insurance to be billed first)</i>	
<b>Policy Number or Member ID:</b>	<b>Group Number:</b>
<b>Secondary Insurance Company:</b> <i>(if applicable)</i>	
<b>Policy Number or Member ID:</b>	<b>Group Number:</b>



**PREFERRED PHARMACY**

<b>Pharmacy Name:</b>	<b>Phone Number:</b>
<b>Pharmacy Address:</b> <i>(street, city, state, zip)</i>	

**MEDICATIONS AND PAST MEDICAL HISTORY**

*IF MORE THAN SIX MEDICATIONS- A LIST IS REQUIRED*

**Are you currently prescribed any medications?**  Yes  No  
**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name of the Drug	Strength	Frequency Taken

**Allergies to medications or medical supplies such as latex, adhesive tape, or local anesthetic:**

Name of the Drug or product	Reaction You Had

<b>Are you Diabetic or Pre-Diabetic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list your most recent Hemoglobin A1c: <i>(usually a number between 6 &amp; 12)</i>
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<b>Do you have a primary care doctor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Primary care doctor:
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**Have you ever been diagnosed with any of the following? (circle all that apply)**

<ul style="list-style-type: none"> <li>-Cardiovascular problem</li> <li>- Angina</li> <li>- Heart Attack</li> <li>- Heart Disease</li> <li>- Congestive Heart Failure</li> <li>- Blood Clots or DVT</li> <li>- High Blood Pressure</li> <li>- Artificial Heart Valves</li> <li>- Heart Murmur</li> <li>- Skin Disorders</li> <li>- Cellulitis / Skin infection</li> <li>- Large Scars</li> <li>- Slow Healing Sores</li> <li>- Endocrine Disorders</li> <li>- Diabetes</li> <li>- Hypothyroidism</li> <li>-Stomach / Bowel Conditions</li> <li>- GI bleed / Ulceration</li> <li>- Hepatitis</li> </ul>	<ul style="list-style-type: none"> <li>- Kidney Disease</li> <li>- Liver Disease</li> <li>- Nose / Throat Problems</li> <li>- Hearing Loss</li> <li>- Macular Degeneration</li> <li>- Retinopathy</li> <li>- Blindness</li> <li>- Bleeding Disorder</li> <li>- High Cholesterol</li> <li>- Immunologic Disorder</li> <li>- AIDS / HIV</li> <li>- Anaphylactic Reaction</li> <li>- Lupus</li> <li>- Tuberculosis</li> <li>- Swollen Lymph Nodes</li> <li>- Venereal Disease</li> <li>- Rheumatic Fever</li> <li>- Musculoskeletal Disorder</li> <li>- Artificial Joint</li> </ul>	<ul style="list-style-type: none"> <li>- Degenerative Arthritis</li> <li>- Rheumatoid Arthritis</li> <li>- Osteoarthritis</li> <li>- Gout</li> <li>- Back Pain</li> <li>- Fibromyalgia</li> <li>- Osteomyelitis</li> <li>- Neurological Disorder</li> <li>- Neuropathy</li> <li>- Sciatica</li> <li>- Seizure Disorder</li> <li>- Stroke</li> <li>- Depression</li> <li>-Chemical Dependency</li> <li>- Respiratory Disorder</li> <li>- Asthma</li> <li>- Pulmonary Embolism</li> <li>- Shortness of Breath</li> <li>- Cancer</li> </ul>
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### Surgeries

Year	Reason	Hospital

#### Other hospitalizations

Year	Reason	Hospital

**Have you ever had complications or infections from past medical interventions?**    Yes    No

**If yes, please explain below**

**Date:**

**Nature of Complication:**

### HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat on an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
<b>Alcohol</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years:	<input type="checkbox"/> Or year quit:	
<b>Personal Safety</b>	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No



## FAMILY HEALTH HISTORY

PLEASE LIST ANY *SIGNIFICANT* HEALTH PROBLEMS ASSOCIATED WITH THE APPROPRIATE RELATION BELOW

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

## PODIATRIC HISTORY

<b>What is the chief reason for being seen today?</b>	
<b>Is this condition the result of a work injury?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please briefly explain below

<b>Which Foot / ankle is affected?</b>	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<b>How Long has the condition been present?</b>			



<p><b>What is the quality of the ailment pain?</b></p> <p><i>(mark all that apply)</i></p>	<input type="checkbox"/> Aching <input type="checkbox"/> Stabbing <input type="checkbox"/> Pain after rest <input type="checkbox"/> Sharp <input type="checkbox"/> Pins & needles <input type="checkbox"/> Dull <input type="checkbox"/> Nauseating <input type="checkbox"/> Crushing <input type="checkbox"/> Tender <input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Inconsistent <input type="checkbox"/> Pulling <input type="checkbox"/> Swelling <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Disabling <input type="checkbox"/> Constant <input type="checkbox"/> Radiating	
<p><b>What is the usual onset of the pain?</b></p> <p><i>(mark all that apply)</i></p>	<input type="checkbox"/> Gradual <input type="checkbox"/> With exercise <input type="checkbox"/> Sudden <input type="checkbox"/> Unknown <input type="checkbox"/> Primarily at night	
<p><b>What is the cause of the ailment?</b></p> <p><i>(mark all that apply)</i></p>	<input type="checkbox"/> No trauma <input type="checkbox"/> Auto accident <input type="checkbox"/> Improper foot gear <input type="checkbox"/> Work injury <input type="checkbox"/> Blunt injury <input type="checkbox"/> Trip or fall <input type="checkbox"/> Sports injury <input type="checkbox"/> Other <input type="checkbox"/> Cut from sharp object <hr/>	
<p><b>What treatments, if any, have you tried pain?</b></p> <p><i>(mark all that apply)</i></p>	<input type="checkbox"/> None <input type="checkbox"/> Physical therapy <input type="checkbox"/> Orthotics / arch support <input type="checkbox"/> Antibiotics <input type="checkbox"/> Change / modify shoe gear <input type="checkbox"/> NSAIDs <input type="checkbox"/> Other <hr/>	
<p><b>Have you ever seen a podiatrist before?</b></p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If yes, who was the doctor and what was the circumstance?</p>



**CONSENT OF RELEASE**

In my absence, I authorize Dr. Spence D. Harper's office to release all or portions of my medical records to those as indicated below. This authorization is in effect for a full year or until I revoke it in writing.

*Ex: Family Members or Doctors Offices*

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

X \_\_\_\_\_  
Signature of patient or parent / authorized representative

X \_\_\_\_\_  
Date

**HIPAA NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided access to a copy of the **Privacy Practices Policies** and that I have read (or had the opportunity to read if I so chose) and understand the notice.

X \_\_\_\_\_  
Signature of patient or parent / authorized representative

X \_\_\_\_\_  
Print Name

X \_\_\_\_\_  
Date

**FINANCIAL AGREEMENT, RELEASE & TREATMENT CONSENT**

- > I request that payment of authorized insurance benefits be made on my behalf to Dr. Spence D. Harper or Wasatch Foot and Ankle Center for any service furnished. I authorize the release of medical information about me needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.
- > I understand that I am financially responsible for all charges whether or not paid by insurance. A financial fee of 1.5% per month will be added to all accounts past due. Delinquent accounts over 90 days past due will automatically be sent to a collection agency. Should collections become necessary, the responsible party agrees to pay an additional 35% collection fee and all legal fees, with or without suit including attorney fees and court costs. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.
- > I understand that I may be billed for appointments that I miss without cancelling or rescheduling at least 24 hours in advance.
- > I certify that the above information is true and correct to the best of my knowledge. I hereby give my permission to Dr. Spence D. Harper and Wasatch Foot and Ankle Center to administer and perform such procedures and tests as may be deemed necessary in the diagnosis and treatment of my feet/ankles. I authorize the use of photography for documentation and/or educational purposes.

X \_\_\_\_\_  
Signature of patient or parent / authorized representative

X \_\_\_\_\_  
Date

