CENTRAL | TENNESSEE
FOOT and ANKLE CENTER

Jeffery Loveland DPM

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Name: Last_____ **First**_____ **MI**_____
Address: Street_____ **City**_____ **ST**_____
Phone: (_____) _____ **Cell: (_____)** _____ **Work: (_____)** _____
Sex: M F Birth year_____ **Social Security #** _____ **Email**_____
Race_____ **Religious Affiliation**_____ **Marital Status: S M D W DP**
Employer:_____ **Occupational Title**_____

Primary Care Physician_____ **City**_____ **Phone (___)**_____
Most Recent Visit_____
Preferred Pharmacy_____ **City**_____ **Mail Order Pharmacy**_____

Guardian / Guarantor (Skip if patient)
Name: Last_____ **First**_____ **MI**_____
Address: Street_____ **City**_____ **ST**_____
Phone: (___) _____ **Cell: (___)** _____ **Work: (___)** _____
Sex: M F Birth year_____ **Social Security #** _____ **Email**_____

Emergency Contact :_____**(____)** _____**Relationship**_____
How did you hear of our practice? _____
Accident information
Is your visit today related to a work related injury or accident? _____YES _____NO
Injury Date _____ **Claim Number** _____ **Auto____ Work____ Other___**
Adjuster/ Responsible Party _____ **Address**_____
Phone (____) _____ **FAX (____)** _____
What is your chief foot/ankle complaint today_____

_____

When did these begin_____ **previous treatments for this problem?** _____

Have you ever had your feet or ankles treated before for other problems? _____YES _____NO

If yes please explain

_____

_____

_____

_____

USE OF ALCOHOL: _____ CURRENT USE ____NEVER _____ NO LONGER USE _____HISTORY OF ALCOHOL ABUSE

TYPE _____ ___RARE ____OCCASIONAL ___ MODERATE ___DAILY

USE OF TOBACCO: ___NEVER ____SMOKE /DIP ____ PACKS/DAY FOR ____ YEARS _____QUIT – HOW LONG AGO? _____

USE OF RECREATIONAL DRUGS: ___NEVER ___QUIT – HOW LONG AGO? _____ TYPE _____

CURRENT USE – TYPE _____ ___RARE ___OCCASIONAL ___ MODERATE ___ DAILY

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ ADHD
- ❑ Anemia
- ❑ Arthritis Osteo_____ Rheumatoid_____
- ❑ Asthma
- ❑ Back Pain C___ T____ L____ Spine
- ❑ Blood Clots
- ❑ BPH
- ❑ Cancer Type_____
- ❑ Cataracts
- ❑ Chest Pain
- ❑ Diabetes Type I___ II____ Insulin___
- ❑ Emphysema
- ❑ Epilepsy / Seizures
- ❑ Fibromyalgia
- ❑ GERD
- ❑ Gout
- ❑ High Blood Pressure
- ❑ Heart Problems _____
- ❑ Hepatitis A B C
- ❑ High Cholesterol
- ❑ Kidney Disease/Failure
- ❑ Migraine Headaches
- ❑ Neuropathy
- ❑ Parkinson's
- ❑ PTSD
- ❑ Restless Leg Syndrome
- ❑ Sleep Apnea
- ❑ Stomach Ulcer
- ❑ Stroke / TIA
- ❑ Thyroid Problems
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Dementia/ Alzheimer's
- ❑ Depression / Anxiety
- ❑ Heart Failure
- ❑ Hiatal Hernia
- ❑ IBS
- ❑ Leukemia
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

_____ _____

_____ _____

_____ _____

_____

MOST RECENT _____ FOR DIABETICS _____

HEIGHT _____ WEIGHT _____ RECENT BLOOD PRESSURE _____ A1C _____ GLUCOSE _____

Previous Surgeries

Appendix _____ Back_____ C-Section_____ Cataracts ____Colonoscopy ____D&C_____ Ear Tubes ____Eyes ____

Gall Bladder____ Gastric Bypass ____ Hysterectomy ____ Knee Scope___ Lasik ____ LEEP ____

Mastectomy R/L____ Oral Surgery ____ Sinus ____ Skin Cancer ____ Tonsils ____ Tubal Ligation____

Joint replacements_____

OTHER_____

_____

_____

SURGICAL IMPLANTS

____PACEMAKER _____ INSULIN PUMP _____ SPINAL CORD STIMULATOR _____ JOINT REPLACEMENTS _____OTHER

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Include all prescription and over-the-counter medications (example: aspirin, antacids, vitamins) and herbals (example: ginseng, gingko). Also include medications taken only when needed (ex: nitroglycerin, Tylenol).

NAME OF MEDICATION / DOSE / FREQUENCY	Reason for Taking	Doctor Name

Are you under the care of a Pain Management Provider? ___YES ___NO If yes who

Address **Phone**

Medication Allergies: (Circle all that apply) **NONE**

Aspirin, Adhesive Tape, Ceclor, Codeine, Contrast Dye, Cortisone, Demerol, Iodine, Latex, Levaquin, Morphine, NSAIDS, Novocain, Penicillin, Seafood, Sulfa, Tetanus, Toradol, Ultram

Other:_____

Do you have any Metal Allergies? ____Yes ____No

Family Medical History (please enter approximate age diagnosed if known)

	Mother Alive/ Deceased	Father Alive/ Deceased	Siblings
Diabetes	_____	_____	_____
Hypertension	_____	_____	_____
Heart Disease	_____	_____	_____
Cancer	_____	_____	_____
Sickle Cell	_____	_____	_____
Other_____	_____	_____	_____

CONSENT TO TREATMENT

I request those physicians and other health care professionals who care for me to perform diagnostic Procedures, hospital care and therapeutic treatments, which in their judgements, become necessary while I am a patient with CTFA. Routine diagnostic procedures and medical treatments include but not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical recording or filming necessary in the judgment of my physician to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education

REFERRALS

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize CTFA to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my hospitalization. If I undergo any procedure that requires the submission of pathologic examination, I authorize the use of any excess tissue for educational purposes.

RELEASE OF PATIENT'S RESPONSIBILTY

I understand that if I leave CTFA without consent of the physician and/or fail to carry out instructions for follow-up care. I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from CTFA will be my responsibility. I understand that it is my responsibility to keep my appointments scheduled, so that Dr. Loveland can continue the highest quality of care for my needs.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

SIGN_____**DATE**_____

DISCUSSION OF MEDICAL TREATMENT HIPPA

List the family members or other person, if any, whom we can discuss your medical treatment with.

Circle how we may leave information regarding appointments, test or lab results.

Voicemail family member spouse

Name_____Relationship_____

Name_____Relationship_____