UPDATE FORM
Established Patients Only

New Patients and Patients not treated in 3 years complete the Demographic and Medical Forms – Not This Form

Patients Full Name_____ DOB_____

Mailing Address_____

City_____ State_____ Zip_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widow

Home Phone_____ Cell Phone_____ Work Phone_____

Primary Care Physician_____ Date Last Seen_____

Date of Flu Vaccine_____ Date of Pneumonia Vaccine_____

Phone Number_____ Fax Number_____

Address_____

City_____ State_____ Zip_____

EMERGENCY CONTACT_____ Phone_____ Relationship_____

Primary Insurance Carrier_____

Group Number_____ ID Number_____

Policy Holders Name _____ SSN_____ DOB_____

Secondary Insurance Carrier_____

Group Number_____ ID Number_____

Policy Holders Name_____ SSN_____ DOB_____

Change in Medication YES ❑ NO ❑

****IF YES – PROVIDE UPDATED MEDICATION LIST****

I authorize Associated Foot Surgeons, it's representative, physicians and staff to transmit messages related to my healthcare and appointment reminders via
❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email _____

I authorize Associated Foot Surgeons to release information to:

Name_____ Relationship _____

Phone _____ Medical❑ Financial❑

Name_____ Relationship _____

Phone _____ Medical❑ Financial❑

_____ _____ _____

Form Completed By – Print Name Signature Date

Relationship to Patient ❑ Self ❑ Father ❑ Mother ❑ Legal Guardian ❑ Other:_____

CHANGE IN HEALTH STATUS **IF YES – SEE REVERSE**

No Change in Health Status – Skip This Side Only

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Allergic or Sensitive to: ❑ Tape ❑ Latex ❑ Shellfish ❑ Iodine ❑ Other_____
❑ Medications_____ ❑ Anesthesia_____ ❑ No Known Allergies

Any problems with local anesthetic (Novocaine, Lidocaine) ❑ Yes ❑ No If yes, describe

_____

Have you had any problems taking aspirin or ibuprofen (Advil, Motrin, etc) ❑ YES ❑ NO

Medications you are taking ❑ See List ❑ Not currently taking medications

_____

_____

MEDICAL HISTORY – IF YES – CIRCLE THE APPROPRIATE NUMBER

1	Acid Reflux	11	Anemia	21	Arthritis	31	Angina	41	Abnormal Bleeding
2	Artificial Joint(s)	12	Asthma/Bronchitis	22	Bladder Infections	32	Back Trouble	42	Blood Clots
3	Blood Transfusion	13	Cancer	23	Cancer of Skin	33	Diabetic: Type 1 or 2	43	Epilepsy
4	Fibromyalgia	14	GERD	24	GOUT	34	Heart/Disease/Failure	44	High Blood Pressure
5	Kidney Stones	15	Leg/Feet Cramps	25	Liver Disease	35	Low Blood Pressure	45	Lung Disease
6	Neuropathy	16	Open Sores	26	Phlebitis	36	Psychiatric Disorder	46	Peripheral Vascular Disease
7	Pneumonia	17	Respiratory Disease	27	Rheumatoid Arthritis	37	Radiation Therapy	47	Restless Leg Syndrome
8	Rheumatic Fever	18	Skin Disorder	28	Sleep Apnea	38	Sickle Cell Disease	28	Skin Disorder
9	Stroke	19	Steroid Treatment	29	Thyroid Disease	39	Varicose Veins	49	Tuberculosis
10	Hepatitis	20	MRSA Infection	30	HIV+/AIDS	40	Other	50	Family Member Deceased

FAMILY HISTORY

Family history of the above listed items? If so, indicate who with the corresponding number

Mother_____ Father_____ Sister_____ Brother_____

Diabetes ❑ YES ❑ NO How long_____ Insulin ❑ YES ❑ NO

History of smoking or tobacco use ❑ YES ❑ NO If yes, how much per day_____
If no, have you smoked or used tobacco in the past ❑ YES ❑ NO Years____ Year Quit_____

Do you drink alcohol/beer ❑ YES ❑ NO
❑ If yes, 1-2 per week ❑ 1-2 per day ❑ More than 2 daily