Lansdowne Foot & Ankle Center

Patient Medical History Form

If you are unable to print and complete this form prior to the appointment, please arrive 20 minutes early.

Last Name:____ First Name:_________________________________ MI:_______

☐Male ☐Female ☐Undifferentiated Height: __________ Weight: ___________ Shoe Size: _______________

History of Present Illness:

1. What specific problem brings you to our office today? ____
2. Where is the pain/condition located? ☐left foot/ankle ☐right foot/ankle ☐both
3. How long ago did this problem first start? ________________________________
4. How would you describe the nature of your pain? ☐Sharp ☐Dull ☐Aching ☐Burning ☐Radiating ☐Itching ☐Stabbing ☐Throbbing ☐Sore Other:_______________
5. How would you rate your pain on a scale of 0 to 10? _______
6. What seems to make the pain/condition feel worse? ☐Walking ☐Standing ☐Resting ☐Dress Shoes ☐Flat Shoes ☐Any Closed Shoe ☐Daily Activities ☐Exercise
7. What makes the condition feel better? ____
8. What treatments have you tried for this condition? ____
9. Is the problem the result of an injury? ☐YES ☐NO If yes, is it work related? ☐YES ☐NO
10. Do you participate in competitive sports? ☐YES ☐NO

Allergies:
☐ None
☐ Adhesive Tape
☐ Iodine/Shellfish
☐ Penicillin
☐ Aspirin
☐ Local Anesthetics
☐ Sulfa
☐ Codeine
☐ Demerol
☐ Novocaine

Other: ___________________

Medications: (include all prescriptions, over-the-counter medications and vitamins)

Previous Surgeries: (please list & include dates)

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(continued)

	YES	NO
Anemia	☐	☐
Asthma	☐	☐
Chest Pain	☐	☐
Ear Problems	☐	☐
Gout	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Migraine	☐	☐
Radiation Treatment	☐	☐
Sinus Problems	☐	☐
Varicose Veins	☐	☐

	YES	NO
Angina	☐	☐
Back Problems	☐	☐
Chronic Diarrhea	☐	☐
Epilepsy	☐	☐
HIV/AIDS	☐	☐
Heartburn	☐	☐
Liver Disease	☐	☐
Neuropathy	☐	☐
Respiratory Disease	☐	☐
Special Diet	☐	☐
Venereal Disease	☐	☐

	YES	NO
Arthritis	☐	☐
Bleeding Disorders	☐	☐
Circulation Problems	☐	☐
Eye Problems	☐	☐
Headache	☐	☐
Hemophilia	☐	☐
Low Blood Pressure	☐	☐
Phlebitis	☐	☐
Rheumatic Fever	☐	☐
Stroke	☐	☐

	YES	NO
Artificial Joints	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Fainting or Dizzy Spells	☐	☐
Hepatitis	☐	☐
Mental Health Disorders	☐	☐
Pneumonia	☐	☐
Shortness of Breath	☐	☐
TB	☐	☐

Other:___________________

Women Only

	YES	NO
Are You Pregnant	☐	☐
Breast Feeding	☐	☐
Regular Menstrual Cycle	☐	☐

Family History: (Please list all medical conditions that run in the family)

Social:

	YES	NO		
Do you smoke?	☐	☐	If YES, what type/ frequency?	
Do you drink alcohol?	☐	☐	If YES, how much?	
Do you use drugs	☐	☐	If YES, what type/ frequency?	

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Patient Medical History Form

(continued)

Review of Systems: Are you experiencing any of the following conditions?

Constitutional	YES	NO
Fever / Chills	☐	☐
Nausea / Vomiting	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐

Eyes	YES	NO
Blurry Vision	☐	☐
Double Vision	☐	☐
Eyeglass Use	☐	☐
Recent Injury	☐	☐

Ears/Nose/Throat	YES	NO
Nosebleeds	☐	☐
Sinus Infections	☐	☐
Hearing Impairment	☐	☐
Difficulty Swallowing	☐	☐
Frequent Sore Throats	☐	☐

Respiratory	YES	NO
Difficulty Breathing	☐	☐
Lung Disease	☐	☐
Short of Breath	☐	☐

Cardiovascular	YES	NO
Arrhythmia	☐	☐
Chest Pain	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Leg Pain - Walking	☐	☐
Palpitations	☐	☐

Gastrointestinal	YES	NO
Abdominal Pain	☐	☐
GI or Rectal Bleeding	☐	☐
GI Upset	☐	☐

Musculoskeletal	YES	NO
Joint Pain	☐	☐
Joint Stiffness	☐	☐
Lower Back Pain	☐	☐
Swelling	☐	☐

Psychiatric	YES	NO
Anxiety	☐	☐
Depression	☐	☐
Nervousness	☐	☐

Skin	YES	NO
Edema or Swelling	☐	☐
Itching	☐	☐
Rashes	☐	☐

Neurological	YES	NO
Burning	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Tingling	☐	☐

Endocrine	YES	NO
Cold Intolerance	☐	☐
Excessive Thirst	☐	☐
Excessive Urination	☐	☐
Heat Intolerance	☐	☐
Hormonal Problem	☐	☐

Hematologic / Lymph	YES	NO
Blood Clots	☐	☐
Phlebitis	☐	☐

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

______________________________	______________________________	__________
Print Name of Patient, Parent or Guardian	Signature of Patient, Parent or Guardian	Date

Personal Information*

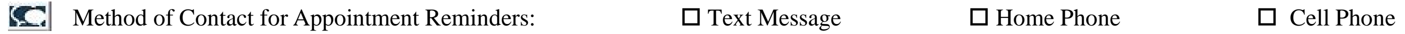
PATIENT INFORMATION

Prefix: Mr./Mrs./Other:________Patient Name*:____Suffix: Jr./Sr./Other: _________
Last First Middle Initial

Previous Name: ___________________ Preferred Name: ________________ Email: ____

Mailing Address*: ____
Street Address Apt. # City State Zip

Home #:_________________________Cell #:_____________________________Work #:_________________________Ext: __________



Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP):______________________________Address:_____________________________Phone #: ________________
First Last

Referring Provider:_______________________________Address:_________________________________Phone #: _________________
First Last

Date of Birth*:______________Birth Sex*:________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
mm/dd/yyyy

Social Security #:_______-______-________Employer Name:__________________________________Occupation:__________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other:_________________________

Ethnicity*: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino

Gender Identity: ☐ Male ☐ Female ☐ Female-To-Male (FTM)/Transgender Male/Trans Man ☐ Male-To-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose ☐ Other, please specify: ______________

Language*: ☐ English ☐ Spanish ☐ Other: ____________________________________

Sexual Orientation: ☐ Lesbian, gay/homosexual ☐ Straight/heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose

☐ Something else: ________________

Pharmacy Name*:_______________________________Address:_____________________________________Phone #:

Emergency Contact*

Name:____Relationship: ____
Last First

Address: ____
Street Address Apt # City State Zip

Home #:__________________________Work #:__________________________Cell #: ________________________

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name:_______________________________________Date of Birth:________________Birth Sex:___Social Security #:_____-______- ______
Last First mm/dd/yyyy

Address: ____
Street Address Apt # City State Zip

Home #:_________________________Cell #:_____________________________Work #:_________________________Ext: __________

Primary Insurance Information*

Insurance Name:___________________________Member ID #:_________________________Relationship to Insured:____________________

Employer:_____________________________________Group #:___________________________Effective Date: ______________________
mm/dd/yyyy

Insured's Information* - (if not self)

Name:_______________________________________Date of Birth:________________Birth Sex:____Social Security #:____-______- ______
Last First mm/dd/yyyy

Relationship to Insured:________________________________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: ____
Street Address Apt # City State Zip

Home #:__________________________Work #:__________________________Cell #: ________________________

Secondary Insurance Information

Insurance Name:___________________________Member ID #:_________________________Relationship to Insured:____________________

Group#:_________________________________Effective Date: ________________________

Secondary Insured's Information - (if not self)

Name:_______________________________________Date of Birth:________________Birth Sex: _____Social Security #:____-____- _______
Last First mm/dd/yyyy

Relationship to Insured:________________________________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: ____
Street Address Apt # City State Zip

Home #:__________________________Work #:__________________________Cell #: ________________________

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. **X_______ (Please initial)**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X_________(Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X________(Please initial)**

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents
X_______ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out
X______ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X________(Please initial)**

____ ____________________
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

____
Relationship (if any)