WELCOME TO OUR OFFICE

J.B. Jenkins & Associates — Podiatrists & Foot Surgeons — 1706 E. 87th Street, Chicago, IL 60617 — (773) 374-5300

Name: _____ Date: _____/_____/_____

Address: _____ City: _____ Zip Code: _____

Social Security Number: _____ (Must Provide for Insurance Billing Purposes:)

Birth Date: _____/_____/_____ (MM/DD/YYYY) Sex: M / F (circle one) Email: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

Name of your Primary Doctor (PCP): _____

How did you hear about this office? (check one) Dr. Referral _____ Friend/Family _____

Internet/Google _____ Insurance Company _____ Facebook _____ Other _____

Insurance Information:

Name of Primary Insurance: _____ ID Number: _____

Secondary Insurance: _____ ID Number: _____

Please Describe what brings you in today: _____

Where does it hurt? _____

How Long have you had this problem?: _____

Please describe the type of pain you have (circle ALL that apply):

Aching	Constant	Cramping
Comes and Goes	Dull	Pins and Needles
Sharp	Stabbing	Throbbing

If it an injury, when did it happen? _____

How did it happen?_____

On a scale of 1-10, (circle one) how severe is the pain? _____

NO PAIN 1 2 3 4 5 6 7 8 9 10 SEVERE Where does it occur? _____

I DO HEREBY grant permission to Dr. J.B. Jenkins & Associates to administer and perform procedures as may be deemed necessary in the interest and care of me. I understand I am responsible for paying any or all balances due for service rendered. I understand that release of my Medical Records will incur a cost of $25.00 (minimum) and release of records will require full payment and my WRITTEN authorization. I understand that release of these records will take a minimum of 30 days. I authorize Dr. Jenkins & Associates to furnish my insurance company for with all necessary information regarding my present illness or injury and, I authorize any necessary test, laboratory tests, x-rays and/or hiv/aids tests to be performed if the doctor deems necessary. I also authorize this office to receive any medical records, test results or other medical information from any of my other providers related to my medical treatment here.

Signature of Patient/Guardian _____

SOCIAL HISTORY:

DO YOU EXERCISE REGULARLY? _____NO _____ YES (WHAT TYPE AND HOW OFTEN?) _____

DO YOU DRINK ALCOHOL? _____NO _____ YES (HOW MANY DRINKS PER WEEK?) _____

DO YOU SMOKE? _____NO _____YES (HOW MANY PER DAY?)_____ HOW LONG? _____

WHAT IS YOUR OCCUPATION? _____

HOW MANY YEARS OF SCHOOL? _____

MARITAL STATUS: _____ NAME OF SPOUSE OR PARENT (IF MINOR) _____

HEIGHT: _____ WEIGHT: _____

DO YOU HAVE ANY ALLERGIES? PLEASE LIST AND DESCRIBE REACTION:

_____

_____

WHICH PHARMACY DO YOU USE? _____ PHONE: (_____) _____

LIST ALL MEDICATIONS YOU ARE NOW TAKING—PRESCRIPTION AND OVER–THE-COUNTER MEDICINE

NAME OF MEDICATION	DOSAGE (EX. 10MG)	HOW OFTEN DO YOU TAKE IT?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY THAT YOU HAVE HAD):

ARTHRITIS	ASTHMA	BLEEDING PROBLEMS	BLOOD CLOTS
CANCER	DIABETES	EMPHYSEMA	HEART PROBLEMS
HIGH BLOOD PRESSURE	HIV/AIDS	IRREGULAR HEARTBEAT	KIDNEY FAILURE
MINAL VALVE PROLAPSED	OTHER INFECTION	PSORIASIS	RHEUMATOID ARTHRITIS
SEIZURES	STROKE	THYROID PROBLEMS	TUBERCULOSIS
ULCERS	URINARY INFECTION	VARICOSE VEINS	_____

REVIEW OF SYSTEMS:

BRUISE EASILY	EXCESSIVE THIRST	EXCESSIVE URINATION	EXTREMITY SWELLING
EXTREMITY WEAKNESS	JOINT PAIN	LOSS OF SENSATION IN FEET	MUSCLE PAIN
PALPATION OR FLUTTERING HEART	SHORTNESS OF BREATH	TROUBLE WALKING	USE OF CANE OR WALKER

PAST FAMILY HISTORY: Please circle any of the following medical problems of your immediate family (Father, Mother, Brother, Sister, Grandparents) has had:

Anesthesia Problems Arthritis Blood Clot Diabetes Heart Problems Foot Problems

Circle which family member? Father Mother Sister Brother

Grandparents (Maternal/Paternal)

PAST SURGICAL HISTORY: (Please describe any PAST Surgeries you have had (include the year):

_____

_____

_____

_____

_____

_____

SPECIAL CONDITIONS

Cultural or Religious Belief: ——- NO _____YES Specify: ————————————

Language: English_____ Spanish_____ Other_____ Translator Needed:_____

Learning Variables None_____ Hearing_____ Vision_____

Cognitive Impairment ____Illiterate_____ Pain_____ Anxiety_____

Ready to Learn?: NO_____ YES_____

Learning Preference _____written _____Verbal _____Demonstration

Personal History: _____Alcohol _____Drug Use/Abuse _____Advanced Directive