Charlotte Family Podiatry and Wound Center

Magdy Issa, DPM
Phone or Text: (980) 220-2028
Email: Dr.Issa@charlottefamilypodiatry.com

Name (First, Middle Initial, Last)	Gender	Date of Birth	Age
Street Address City State Zip	Email Address		
Home Telephone Number	Cell Number		

In the event our office needs to get ahold of you to relay diagnostic, lab or imaging results, please share ☐I do not wish to have messages left which method we can leave confidential messages (if applicable): ☐Home Phone ☐Cell Phone ☐Email containing health information anywhere

Race	Ethnicity	Marital Status S M D W	Primary Care Physician

How did you hear about our office? ☐Dr. ________________________ ☐ Friend/Family __________________________

☐Yelp ☐ NextDoor ☐Insurance Website ☐Internet Search ☐Other _______________________________________

Employer Name	Occupation	Work Telephone Number

Emergency Contact: Name, Relation, Phone Number

I authorize my medical information to be shared with the following individual: ☐I do not authorize the release to anyone

Name	Relationship	Telephone Number

Responsible Party ☐Same as above Name Relationship Telephone Number

Address (if different than above)

Insurance Information Primary Insurance Carrier Secondary Insurance Carrier

Are you the subscriber? ☐Yes ☐No Subscriber name and DOB (if you are the dependent): ______________________________________

By signing this I understand that payment for office visits or any procedures are expected when services are rendered unless other arrangements have been made in advance. I recognize that professional services are rendered and charged to me and not to my insurance company. I know and understand that I am responsible for any non-covered services as well as copayments and deductibles. I understand that proof of eligibility, coverage and non-covered services and various exclusions frequently cannot be determined until my carrier processes the claim. I know that billing insurance companies is a courtesy to me and that this podiatry office cannot accept the responsibility for collecting, negotiating or settling a disputed claim. I understand that filing of insurance claims does not guarantee payment by my carrier. **If my insurance company does not reimburse the office within 90 days of providing services, I agree to pay for the services myself** and, in turn, collect the reimbursement from my insurance company. While the office tries to comply with the requirements of my insurance companies, it is ultimately my responsibility to be aware of the limits and qualifications of my own policy, including the requirements for second opinions, pre authorizations assistant surgeon and orthotic coverage. I agree to pay for any treatment I receive that my insurance company will not pay for. I understand that an

Date: _____________________ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ____

PREFERRED NAME: ______________________________

LOCAL PHARMACY (please be specific with location): ____

HEIGHT: ___________ WEIGHT: ____________ SHOE SIZE: ___________ (NARROW/REGULAR/WIDE/XTRA WIDE)

WHAT SPECIFIC FOOT PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

____

____

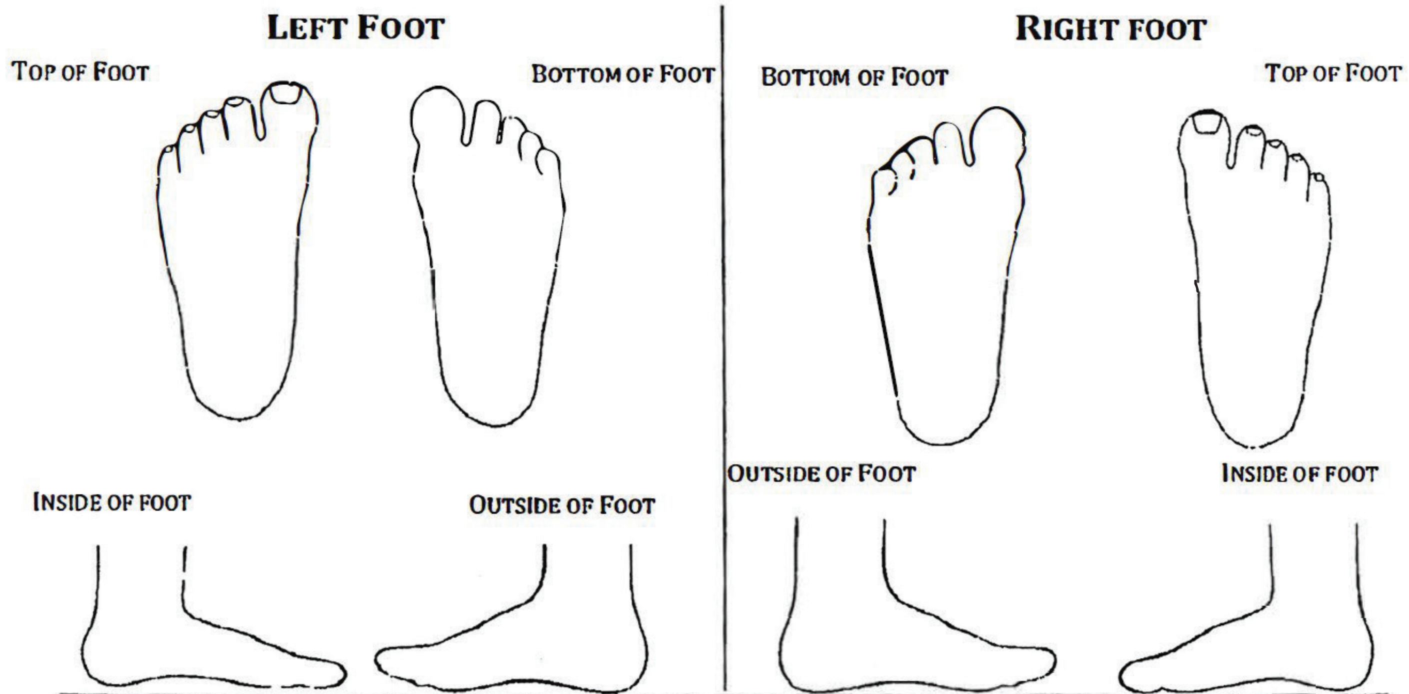
DO YOUR NAILS OR CALLUSES HURT? ☐ NO ☐YES (IF YES, PLEASE MARK TOE(S) ON IMAGES BELOW)

DO YOU USE BLOOD THINNERS LIKE COUMADIN, ELIQUIS, PLAVIX, ETC? ☐YES:______________ ☐NO

IF YES, WHICH DOCTOR PRESCRIBES THIS MEDICATION AND WHEN WERE YOU LAST SEEN: ___________________________

DO YOU HAVE POOR BLOOD FLOW, COLD FEET, CRAMPING OR PAINFUL LEGS WHEN WALKING? ☐YES ☐ NO

WHERE IS YOUR TOENAIL/FOOT PAIN LOCATED? *PLEASE MARK ON THE IMAGES BELOW*



THIS PROBLEM: ☐ DEVELOPED ALL OF A SUDDEN ☐GRADUALLY DEVELOPED OVER TIME

☐CAUSED BY AN INJURY (IF SO, PLEASE DESCRIBE): ____

DESCRIBE THE PAIN: ☐NO PAIN ☐SHARP ☐STABBING ☐DULL ☐ACHING ☐BURNING ☐RADIATING ☐ITCHING

☐OTHER: ______________________ RATE YOUR PAIN (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

OVER TIME HAS THIS PROBLEM: ☐STAYED THE SAME ☐GETTING WORSE ☐IMPROVED

WHAT MAKES YOUR PROBLEM WORSE? ☐WALKING ☐STANDING ☐DAILY ACTIVITIES ☐RESTING ☐DRESS SHOES ☐HIGH HEELS ☐FLAT SHOES ☐ANY CLOSED TOE/TIGHT SHOE ☐RUNNING/HIKING ☐OTHER ____

WHAT MAKES THE PROBLEM BETTER: ____

WHAT TREATMENTS HAVE YOU TRIED: ☐REST ☐ ICE ☐MASSAGE ☐MEDICATION _________ ☐OTHER___________

WHO ELSE HAVE YOU SEEN FOR THIS PROBLEM: ____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK: ______________________________

MEDICAL HISTORY ***(PLEASE PROVIDE A COPY OF MEDICATION LIST OR OTHER PRE-FILLED FORMS)***

ILLNESSES | PRIOR SURGERIES | DATE

___________________________ ___________________________
___________________________ ___________________________
___________________________ ___________________________

MEDICATIONS (INCLUDING PRESCRIBED, OVER THE COUNTER, HERBAL SUPPLEMENTS) ☐***COPY MY MED LIST***

MEDICATION NAME | DOSE | FREQUENCY | PRESCRIBER | REASON

____
____
____
____

HAVE YOU EVER HAD ANY OF THE FOLLOWING

☐DIABETES ☐HEART DISEASE ☐CANCER (TYPE) ________ ☐PACEMAKER ☐AFIB
☐BLOOD CLOT/DVT ☐PVD ☐LEG ULCER ☐PHLEBITIS ☐BLEEDING OR CLOTTING DISORDER
☐MIGRAINES ☐ HEPATITIS ☐HIV ☐GOUT ☐RHEMATOID ARTHRITIS ☐OSTEOARTHRITIS ☐ PSORIASIS
☐LYME DISEASE ☐ ANXIETY / DEPRESSION ☐MEMORY LOSS ☐PSYCHIATRIC CONDITION (TYPE)____________

ALLERGIES ☐NONE KNOWN

☐PENICILLIN ☐SULFA ☐KEFLEX ☐CODEINE ☐MORPHINE ☐ASPIRIN ☐NSAIDS ☐ OTHER ____________
☐ANESTHESIA REACTION ______________________ ☐ FOOD ALLERGY_______________________________

☐TAPE ☐LATEX ☐SHELLFISH ☐IODINE ☐OTHER ____

SOCIAL HISTORY MARITAL STATUS ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED
ALCOHOL USE: ☐NEVER ☐NO LONGER ☐RARE ☐OCCASIONAL / SOCIAL ☐MODERATE
TOBACCO / VAPING: ☐NEVER ☐QUIT – WHEN? ______ ☐OCCASIONAL ☐DAILY ____ PACKS PER DAY
RECREATIONAL DRUGS: TYPE ____________

DO OTHERS DEPEND ON YOU FOR THEIR CARE: ______ CHILDREN (AGES)_____ ☐ELDERLY OR DISABLED FAMILY MEMBER
EXERCISE: ☐NEVER ☐YES BUT NOT CURRENTLY DUE TO INJURY ☐RARE ☐OCCASIONAL ☐WEEKLY ☐DAILY
TYPES OF EXERCISE/SPORTS: ____

EMPLOYER:________________________________ OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

ANYTHING ELSE YOU WOULD LIKE US TO KNOW : ____
____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS, INCLUDING MEDICATIONS.

____ ____
PRINT NAME OF PATIENT (OR PARENT OR GUARDIAN) SIGNATURE

____ ____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

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