Katherine E. Chou, DPM

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Patient Name _____ ☐Male ☐Female
DOB _____ SSN _____ Email _____
Cell#_____ Home#_____ Work#_____
Address _____ City _____State _____ Zip _____

Ethnicity: ☐Hispanic ☐Non-Hispanic
Race:(check all that apply)
☐ African American
☐ Asian or Asian American
☐ Caucasian or European American
☐ Native American or Native Alaskan
☐ Native Hawaiian or Other Pacific Islander
☐ Other

INSURED PERSON
☐Self ☐Spouse ☐Parent ☐Other ☐Self Pay

IF INSURED PERSON IS NOT SAME AS PATIENT, PLEASE COMPLETE THIS SECTION
Subscriber Name _____
Subscriber DOB _____ Subscriber SSN _____

FINANCIALLY RESPONSIBLE PERSON
☐Self ☐Spouse ☐Parent ☐Other
Name and address (if not self) _____
_____
_____

MEDICAL HISTORY

HEIGHT _____ **WEIGHT** _____

SURGERIES OR HOSPITALIZATIONS _____
_____
_____
_____

ALLERGIES
Adhesive tape ☐Yes ☐No If so, what was your reaction? _____
Latex ☐Yes ☐No If so, what was your reaction? _____
Medications ☐Yes ☐No If so, what was your reaction? _____

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PAST MEDICAL HISTORY

- ☐ AIDS/HIV
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer, type? _____
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Falls (recent)
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis, type? ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroidism
- ☐ Incontinence
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ Psychiatric Disorders
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Other

FAMILY MEDICAL HISTORY

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Cancer, what kind? _____

Primary Care Physician_____

SOCIAL HISTORY

☐ Single ☐ Married/Partner ☐ Divorced ☐ Widowed

Who do you live with? _____
Who is your employer? _____
What is your job? _____
Do you smoke? ☐ Yes ☐ No How many per day? _____ Years? _____
Do you drink alcohol? ☐ Yes ☐ No How many? _____ Per ☐ day ☐ week ☐ month
Do you CURRENTLY use any illegal drugs? ☐ Yes ☐ No Which ones? _____

MEDICATIONS (list additional ones on back of sheet)

Medication: _____Strength/Frequency: _____
Medication: _____Strength/Frequency: _____
Medication: _____Strength/Frequency: _____
Medication: _____Strength/Frequency: _____
Medication: _____Strength/Frequency: _____

Do you take any herbal supplements? ☐ Yes ☐ No If so what?_____

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MEDICAL REVIEW OF SYSTEMS

Please check any symptoms you have had in the last month or have questions you would like to ask the doctor about.

General
- ☐ Weight change > 10 lbs
- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Vomiting

Psychological
- ☐ Depression
- ☐ Unable to sleep
- ☐ Thoughts of suicide

Skin
- ☐ Rashes
- ☐ Wounds or breaks in the skin
- ☐ Itching
- ☐ Suspicious moles or spots

Head
- ☐ Headaches
- ☐ Dizziness
- ☐ Recent injury/trauma

Eyes
- ☐ Double vision
- ☐ Dark spots
- ☐ Eye pain or irritation
- ☐ Eye discharge
- ☐ Sudden worsening vision

Ears
- ☐ Decreased hearing
- ☐ Ringing in ears (tinnitus)
- ☐ Bleeding

Nose
- ☐ Nosebleed
- ☐ Cold symptoms
- ☐ Sinus trouble or congestion

Mouth
- ☐ Dentures or partial dentures
- ☐ Loose teeth
- ☐ Toothache
- ☐ Bleeding gums

Neck
- ☐ Stiffness
- ☐ Pain or tenderness
- ☐ Lumps or masses

Breast
- ☐ Lumps
- ☐ Pain or tenderness
- ☐ Swelling
- ☐ Nipple discharge

Heart
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Shortness of breath when lying flat

Lungs
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Cough

Abdomen
- ☐ Changes in appetite
- ☐ Difficulty swallowing
- ☐ Pain or tenderness
- ☐ Changes in bowel habits
- ☐ Red blood in stool
- ☐ Black stool

Urinary
- ☐ Pain during urination
- ☐ Sudden urgency
- ☐ Urinating >3 times in the night

Gynecologic (women only)
- ☐ Menopause
- ☐ Change in menses
- ☐ Pelvic pain
- ☐ Currently pregnant

Muscles and joints (BESIDES foot and ankle)
- ☐ Back pain
- ☐ Joint pain
- ☐ Limited range of motion
- ☐ Swelling in joints
- ☐ Arthritis

Neurologic
- ☐ Weakness
- ☐ Tremor (hands shaking)
- ☐ Seizures
- ☐ Numbness/tingling sensations
- ☐ Paralysis

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OFFICE POLICIES
PLEASE READ CAREFULLY AND INITIAL BY EACH

_____*Privacy Notice (HIPAA)*
I acknowledge I was provided a copy of the Notices of Privacy Practices and I have read, or have had the opportunity to read and understand the notice.

_____*Consent to Treat*
I hereby give my permission to Dr. Katherine Chou, her associates and her assistants, to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition.

_____*Assignment of Insurance and Medicare Benefits*
I authorize payment of medical/Medicare benefits to be sent directly to Dr. Katherine Chou. I authorize Dr. Katherine Chou to furnish necessary information to my insurance company. I acknowledge I was provided a copy of the Patient Insurance Responsibility and I have read, or have had the opportunity to read and understand the notice.

_____*Cancellation Policy and No Show Fees*
I understand that if I am unable to keep an appointment, I will give at least 24 hours notice. I also understand that I will be charged a No Show fee of **$25.00** for each appointment I do not show up for or fail to cancel within 24 hours of the appointment time.

_____*Returned Check Fees*
I understand that I will be charged a Returned Check fee of **$25.00** for each check that is returned or for insufficient funds.

Insured patients understand that all services are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare patient insurance forms for assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by each insurance company.
I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of patient (or financially responsible party) Relationship Date

*The typed name is acceptable as an electronic signature.