VASCULAR & DIABETIC FOOT CENTER

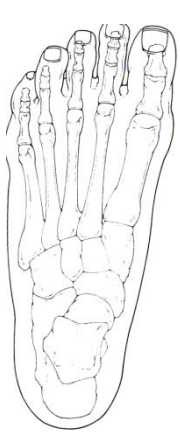
Patient Name: _____ DATE OF BIRTH: _____

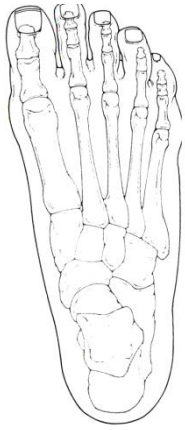
INITIAL PATIENT FORM

Reason for your visit: _____ Visit Date: _____

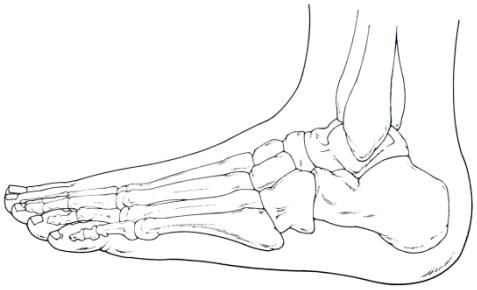
CIRCLE AREA(S) OF CONCERN:

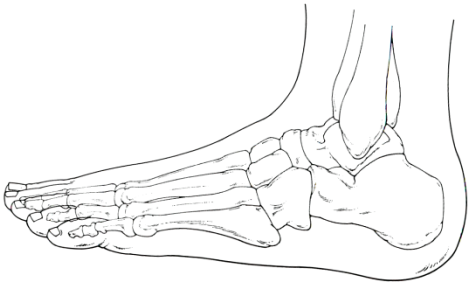
Left Right



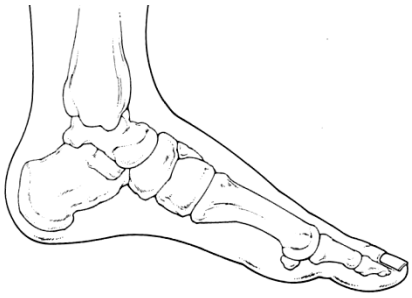


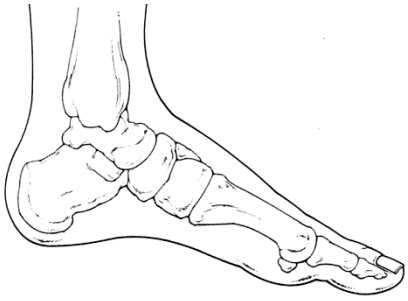
TOP/BOTTOM





OUTSIDE





INSIDE

Type of pain:

□ Sharp	□ Burning	□ Soreness	□ Tightness
□ Stabbing	□ Numbness	□ Aching	□ Pressure
□ Shooting	□ Tingling	□ Throbbing	
□ Pulling	□ Radiating	□ Cramping	
□ Tearing	□ Electric shocks	□ Pins & needles	

Pain Level (0-10): _____

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

REFERING PHYSICIAN: _____

LIST OF TREATING PHYSICIANS (other than Primary Care and Referring):

_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty
_____	_____
Name	Specialty

PHARMACY Name: _____

Street Address: _____

City: _____ Phone: _____

HOME HEALTH AGENCY: Name: _____

Street Address: _____

City: _____ Phone: _____

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

CURRENT MEDICATIONS including over-the-counter & supplements: □ Provided attached list

Name of Medication	Dose	How often taken
Example: Metformin	500 mg	1 tablet, 2 times daily

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

PAST MEDICAL HISTORY (e.g. diabetes mellitus, hypertension, hypercholesterolemia, etc.):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST SURGICAL HISTORY (e.g. appendectomy, tonsillectomy, etc.) including date(s)**:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES / REACTIONS (name & reaction): □ No Known Drug Allergies

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY (not personal) HISTORY: **(Mother, Father, Sibling, etc.)** **□ Adopted – No known family history**

□ Cancer _____ □ Arterial Disease_____ □ Seizures _____

□ Diabetes _____ □ Kidney Disease _____ □ Stroke _____

□ Heart Disease _____ □ Lung Disease _____ □ Heart Attack _____

□ Hypertension _____ □ Mental Illness _____ □ Other _____

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

SOCIAL HISTORY:

Tobacco Use:

□ Current every day smoker: *Year started*: _____ □ *Cigarettes:* ____ *per day* □ *Cigars:* _____ *per day*

□ Former Smoker: *Year quit*: _____

□ Never Smoker

□ Smokeless Tobacco: *Year started*: _____ *Type* _____ *Amount per day* _____

□ Nicotine gum or patch: *Amount per day* _____

□ Electronic Cigarettes: *Year started*: _____ *Amount per day* _____

Caffeine Use: □ *Yes* □ *No* *Type* _____ *Cups per day* _____

Alcohol Use: □ *Yes* □ *No* *Type* _____ *Amount per day* _____

Substance Abuse: □ *Yes* □ *No* *Substance (e.g. cocaine, marijuana)* _____

Illicit Drug Use: □ *Yes* □ *No* *Drug (e.g. OxyContin, Hydrocodone)* _____

Marital Status: _____ # Children: _____ Occupation: _____

Lives in (e.g. home, apartment): _____ Lives with (e.g. no one, spouse): _____

Cultural, Religious, or Language Concerns: _____

ADVANCED DIRECTIVES AND INSTRUCTIONS:

Advanced Directives: _____ □ Do not resuscitate

Durable power of attorney for healthcare: _____

FALL RISK ASESSMENT:

History of Falling: □ *Yes* □ *No*

Secondary Diagnosis (have more than 1 medical diagnosis): □ *Yes* □ *No*

Aids for walking: □ *none/wheelchair/bed rest* □ *crutches/cane/walker* □ *furniture (use for support)*

IV or IV Access: □ *Yes* □ *No* Gait: □ *normal / wheelchair / bed rest* □ *weak* □ *impaired*

Mental Status: □ *oriented/understand own ability* □ *overestimate or forget limitations*

Have you experienced or more falls without injury within past year: □ *Yes* □ *No*

Have you experienced any fall with injury within past year: □ *Yes* □ *No*

VASCULAR & DIABETIC FOOT CENTER

Patient Name: _____ DATE OF BIRTH: _____

Constitutional: □ **None**
□ *chills*
□ *fatigue*
□ *fever*
□ *loss of appetite*
□ *marked weight change*
□ *night sweats*
□ *weight gain*
□ *unintentional weight loss*
□ *weakness*
□ *other:* _____

Eyes: □ **None**
□ *blurred vision*
□ *discharge/drainage*
□ *double vision/spots/flashing lights*
□ *dry eyes*
□ *excessive tearing*
□ *eye pain*
□ *glasses/ contacts*
□ *partial/complete blindness*
□ *sensitivity to light*
□ *vision changes*
□ *other:*

Ears/Nose/Mouth/Throat: □ **None**
□ *bleeding gums*
□ *current infection*
□ *dental problems*
□ *difficulty clearing ears*
□ *bad breath*
□ *hearing loss/aid*
□ *hoarseness*
□ *ear pain*
□ *frequent colds*
□ *loss of smell*
□ *loss of taste*
□ *nasal congestion*
□ *nose bleeds*
□ *earache*
□ *painful/swollen lymph nodes*
□ *post nasal drip*
□ *sore throat*
□ *other:* _____

Cardiovascular: □ **None**
□ *chest pain*
□ *profuse sweating*
□ *difficulty breathing on exertion*
□ *edema*
□ *leg pain when walking*
□ *leg resting pain*
□ *leg swelling*
□ *difficulty breathing laying down*
□ *palpitations*
□ *fainting*
□ *other:*

Gastrointestinal: □ **None**
□ *acid reflux*
□ *bloody stools*
□ *bowel incontinence*
□ *change in bowel habits*
□ *constipation*
□ *diarrhea*
□ *difficulty swallowing*
□ *hemorrhoids*
□ *indigestion*
□ *jaundice*
□ *loss of appetite*
□ *nausea / vomiting*
□ *rectal bleeding*
□ *stomach/abdominal pain*
□ *vomiting of blood*
□ *other:* _____

Genitourinary: □ **None**
□ *abnormal vaginal bleeding*
□ *bladder spasm*
□ *blood in urine*
□ *decreased force in stream*
□ *urinary infrequency*
□ *voiding multiple times at night*
□ *painful urination*
□ *pregnant*
□ *urinary incontinence*
□ *other:* _____

Integumentary: □ **None**
□ *change in hair, skin, nails*
□ *skin dryness*
□ *calluses/corns*
□ *change in mole appearance*
□ *itching*
□ *lesions*
□ *lumps*
□ *prone to skin tears*
□ *rash*
□ *skin allergies*
□ *sun sensitivity*
□ *other:* _____

Endocrine: □ **None**
□ *cold intolerance*
□ *heat intolerance*
□ *excessive thirst*
□ *excessive hunger*
□ *excessive urination*
□ *other:* _____

Musculoskeletal: □ **None**
□ *assistive devices:* _____
□ *backache*
□ *contractures*
□ *decreased activity*
□ *deformities*
□ *joint pain*
□ *joint swelling*
□ *muscle pain*
□ *muscle wasting*
□ *muscle weakness*
□ *other:* _____

Neurologic: □ **None**
□ *abnormal gait*
□ *dizziness*
□ *headaches*
□ *loss of sensation to feet*
□ *memory loss*
□ *numbness*
□ *one-sided weakness*
□ *paralysis*
□ *seizures*
□ *spasms*
□ *tingling*
□ *tremors*
□ *weakness*
□ *other:* _____

Hematologic/Lymphatic: □ **None**
□ *bruising easily*
□ *bleeding/clotting disorders*
□ *bleeding tendency*
□ *blood transfusions*
□ *enlarged lymph nodes*
□ *swelling*
□ *swollen glands*
□ *other:* _____

Allergic/Immunologic: □ **None**
□ *frequent rashes*
□ *hay fever*
□ *hives*
□ *runny nose*
□ *recurrent fevers*
□ *other:* _____

Psychiatric: □ **None**
□ *anxiety*
□ *claustrophobia*
□ *insomnia*
□ *nervousness/tension*
□ *restraints*
□ *suicidal*
□ *memory loss*
□ *depression*
□ *other:*

VASCULAR & DIABETIC FOOT CENTER
PATIENT COMPLIANCE REQUIREMENTS

Treatment of the diabetic foot and/or healing of chronic wounds requires a true commitment to treatment. Time-to-healing for chronic wounds varies from patient to patient, but can take many weeks. You must be willing to commit to this entire time period for the treatment plan to be effective.

Compliance with scheduled appointments, physician orders, home care instructions, and your treatment plan is essential to obtain maximum healing benefits. Patients must be involved in the design of the treatment plan and must comply with the planned frequency and duration of wound care services.

Generally, you will be expected to come to the Vascular & Diabetic Foot Center for appointments with your Physician ***every week.*** You should make all necessary arrangements to come in every week unless otherwise instructed by your Physician.

Patients who do not comply with Vascular & Diabetic Foot Center appointments, physician orders, home care instructions, and/or their treatment plan will be discharged from the Vascular & Diabetic Foot Center and will be required to find another health care provider for their diabetic foot and/or wound care services.

Patients will be considered non-compliant if any of the following occurs:

1. Two (2) “no-show/no-call” missed appointments;

2. Two (2) appointment cancellations without 24 hour notice;

3. Four (4) cancellations in total;

4. Failure to follow physician orders, home care instructions, and/or treatment plan.

Patients who are more than ten (10) minutes late for their scheduled appointment time may need to be rescheduled. Day and time of rescheduled appointments will be dependent upon available openings. We ask that you be on time for all appointments to avoid interfering with other patients’ treatment.

I have read these requirements and have had all of my questions answered regarding these requirements.

I hereby commit myself to following these requirements and my Vascular & Diabetic Foot Center treatment plan.

_____ _____

Patient/Representative Signature Date