Patient ID #_____

HLES
Harford Lower Extremity Specialists
437 South Main St, Bel Air, MD 21014

Welcome to our office!

The following information is needed for proper billing and correspondence. Should this information change, please notify the office. If you have any questions, or difficulty completing this form, please feel free to ask for help.

Please print legibly and use black ink.

Name				Social Security #	
Address				Cell Phone #	
City		State		Zip	
Home #	Preferred contact (*circle*) Home Cell Work Email Text				
Date of Birth	Sex	F M	Marital Status (*circle one* S M W D Separated)		
E-mail					
Patient's Employment	(*circle one)* Full time / Part time / Retired / Disability / Student				
Employer Name:				Work #	
Spouse Name:			Contact Number:		

PERSON RESPONSIBLE FOR BILL (who carries insurance policy)		
Name:	DOB:	Relationship:
Address:		
Home/Cell Phone:	Work Phone	

EMERGENCY CONTACT:	
Name:	Relationship:
Home/Cell Phone:	Work Phone:

RACE							
	Caucasian		African American		American Indian		Asian
	Latin American		No Response		Other:		
ETHNICITY							
	American		German		African		Mexican
	Italian		Chinese		Other:		
PREFERRED LANGUAGE							
	English		Spanish		French		German
	Chinese		Other:				

MEDICAL HISTORY	
Primary Care Physician (Physician where we will send your report)	PCP Office phone #
What problem brings you to our office? (brief description please)	
List all medications you currently use, including over-the-counter, vitamins, etc	
List ALL allergies and the associated reactions:	
Allergic reaction to latex **YES** **NO** Allergic reaction to nickel **YES** **NO**	
*Pharmacy name:	*City/Street:

Your Height:	Weight:
Have you had your flu shot?	Have you had a pneumonia shot?
Have you fallen in the last 6 months?	
Have you had a recent A1C done? (diabetics)	When?
Most recent fasting glucose? (finger stick)	A1C Result?

Are you being seen for an automobile accident or a worker's compensation claim? ( ) no ( ) yes

If yes, please provide the following information: Claim # _____

Contact _____ Phone # _____

MEDICAL ILLNESSES					
Yes	**No**		**Yes**	**No**	
		Anemia			Hormonal Imbalance
		Arthritis			Joint pain or stiffness
		Asthma			Kidney Stones
		Back pain			Liver (jaundice)
		Bladder problems			Lung (pneumonia, TB, etc.)
		Bleeding tendency			Mitral valve, prolapsed/murmur
		Cancer			Neurological disorder
		Chest pain/heart attack			Numbness: FEET / LEGS / BOTH
		Circulation problems			Osteoporosis
		Cramps: FEET / LEGS / BOTH			Parkinson's
		Depression			Problem taking Aspirin and/or Motrin
		Diabetes			Raynaud's disease
		Fibromyalgia			Scarring tendency
		Gall bladder			Shortness of breath (wheezing)
		GERD			Skin disorders
		Heart (CHF, bypass, etc.)			Stroke
		Hearing impaired			Swelling: FEET / LEGS / BOTH
		High blood pressure			Ulcers (leg, stomach)
		Hypothyroidism (thyroid)			Varicose veins
		HIV positive or carrier			Vision impairment

Other Illnesses not listed:

History of Artificial Joints, Stents, or Implants?

History of Physical Therapy?

SURGICAL HISTORY			
Procedure Name	**Date**	**Doctor**	**Facility**

FAMILY HISTORY

Indicate **immediate RELATIVES** that have/had any of the following diseases such as:
Mother, Father, Paternal Grandparents, Maternal Grandparents, Brother, Sister, Aunt, and Uncle.

Arthritis		High blood pressure	
Bleeding disorder		Kidney disease	
Cancer		Mental disorder	
Diabetes		Neurological disorder	
Foot problems		Poor circulation	
Heart disease		Stroke	

SOCIAL HISTORY			
	Do you smoke? Occasionally / Socially / Rarely / Never		Do you exercise?
	Drink alcohol? Occasionally / Socially / Rarely / Never		How often?
	Do you take recreational drugs?		Do you stand or sit at work?

How did you hear about Harford Lower Extremity Specialists? _____