James S. Holdermann, DPM
Heather A. Holdermann, DPM
W. David Goforth, DPM

ACTIVE FOOT & ANKLE CENTER

490 Murphy Road
Medford, OR 97504
541-779-5227
541-779-1938

Name: _____ _____ ____ ☐ Male ☐ Female Email: _____
Last First MI

Phone#: _____ _____ _____ Race/Ethnicity: _____
Home Cell Work

Address: _____ City: _____ State: _____ Zip: _____

Social Security#: _____ Age: ____ Date of Birth: _____ ☐Married ☐Single ☐Divorced ☐Widow

Employer: _____ Address: _____ City: _____ State: ____ Zip: _____

Name of Spouse: _____ Spouse Employer: _____ Spouse phone#: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Referred by? _____ Primary Care Physician: _____

How did you hear about us? ☐Doctor/provider ☐Friend /family ☐Website ☐Social media ☐Search Engine ☐Ad
☐Other_____

☐ **I authorize** the office staff to **share my medical information** with the following family/friends: _____

☐ **I do not authorize** the office staff to **share my medical information** with anyone other than myself.

HEALTH INSURANCE INFORMATION

Is this workman's comp? _____ Company: _____Claim #: _____Adjuster name & phone #: _____

Primary Ins. Co.: _____ Secondary Ins. Co.: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's SS#: _____ Subscriber's SS#: _____

Subscriber's date of birth: _____ Subscriber's date of birth: _____

I declare that the information in this form is true and correct and that I have read and understand the information in this form. I hereby authorize Drs. Holdermann & Goforth to provide medical or emergency care to the above-named person or myself. I authorize my insurance company to pay benefits directly to Dr. James Holdermann, Dr. Heather Holdermann and Dr. W. David Goforth, and I also acknowledge that non-covered services are my responsibility.

I acknowledge that I have been informed of the Notice of Privacy Practices, and that a copy is available upon request.

Signature: _____ **Date**: _____

If patient is a MINOR, please complete this section

Name of Mother: _____ Name of Father: _____

Address (M): _____ Address (F): _____

Social Security # (M): _____ Social Security # (F): _____

Phone # (M): _____ Phone # (F): _____

Employer (M): _____Employer (F): _____

If patient is a minor, I hereby authorize Dr. James Holdermann, Dr. Heather Holdermann and Dr. David Goforth to treat the above-named minor for any medical care.

Signature of parent or guardian: _____ Date: _____

PATIENT NAME: _____ DATE: _____

Height: _____ Weight: _____ Shoe Size: _____

CURRENT PROBLEM: _____

Where? _____ How Long? _____

Previous treatment (x-rays, medication, self-treatment etc.): _____

MEDICAL HISTORY

ALLERGIES: ☐ NONE ☐ Penicillin ☐Sulfa ☐Codeine ☐Aspirin ☐Tape ☐Latex ☐Iodine ☐Shellfish
☐ See attached list

Other Drug Allergies: _____

CURRENT MEDICATIONS:

Your PHARMACY Name/Location:

MEDICAL CONDITIONS

☐ Diabetes – Type _____	☐ Kidney disease	☐ Cancer (type) _____	☐ Lymphedema
☐ High Blood Pressure	☐ Dialysis: Hemodialysis or Peritoneal?	☐ Liver Disease	☐ GERD / Acid Reflux
☐ Heart Attack – When _____	☐ Peripheral Arterial Disease / PAD	☐ Hepatitis (type) _____	☐ Stomach Ulcer
☐ Heart Disease / CAD	☐ Peripheral Neuropathy	☐ Dementia / Alzheimer's	☐ Thyroid Disease
☐ Stroke (CVA) – When _____	☐ Osteoarthritis	☐ Parkinson's	☐ Autoimmune Disease: _____
☐ Atrial Fibrillation / Arrhythmia	☐ Gout	☐ Muscular Dystrophy	☐ Bleeding Disorder: _____
☐ Blood Clot / DVT	☐ Rheumatoid Arthritis	☐ Seizures	☐ Raynaud's Disease
☐ Pulmonary Embolism	☐ Back Problems _____	☐ HIV / AIDS	☐ Sleep Apnea ☐CPAP use
☐ Asthma ☐ COPD	☐ Radiculopathy / Sciatica	☐ **OTHER**: _____	

MAJOR SURGERIES, FOOT SURGERIES/INJURIES

_____
_____
_____
_____
_____

SOCIAL HISTORY

Occupation: _____
Athletic activities: _____
Alcohol: ☐NONE _____ drinks per week
Tobacco: ☐NONE ____ #packs per day for____ years ☐Quit
Drug use: ☐NONE _____

FAMILY HISTORY

☐Heart Disease (who)_____ ☐Blood clot _____ ☐Diabetes _____ ☐Stroke _____
☐Cancer _____ ☐High Blood Pressure _____ ☐Autoimmune Disease _____

REVIEW OF SYSTEMS

Please check any symptoms you are ***CURRENTLY*** experiencing.

Constitutional:	☐ Fever	☐ Chills	☐ Nausea	☐ Vomiting	☐ Weight loss
Skin:	☐ Rash	☐ Calluses	☐ Nail problems	☐ Wounds/Ulcers	☐ Skin cancer
Head/Ears/Eyes:	☐ Blurry vision	☐ Hearing loss	☐ Lumps/masses	☐ Vertigo/dizziness	
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath	☐ Coughing up blood	
Cardiac:	☐ Chest pain	☐ Palpitations	☐ Murmurs		
Gastrointestinal:	☐ Heart burn	☐ Constipation	☐ Blood in stool	☐ Stomach ulcer	
Urinary:	☐ Incontinence	☐ Kidney stones	☐ Excessive urination	☐ Painful urination	
Musculoskeletal:	☐ Joint Pain	☐ Muscle pain	☐ Weakness	☐ Cramping	☐ Limitation of motion
Vascular:	☐ Cold feet/toes	☐ Swelling	☐ Calf pain with walking	☐ Discoloration when exposed to cold	
Neurological:	☐ Foot numbness	☐ Burning/stabbing pain in feet	☐ Weakness or paralysis	☐ Spasms	☐ Abnormal gait
Psychological:	☐ Anxiety	☐ Depression	☐ History of substance abuse		
Endocrine:	☐ Excessive thirst	☐ Excessive sweating	☐ Excessive appetite	☐ Hair loss	☐ Temperature intolerance
Heme/Lymph:	☐ Bleeding disorder	☐ Clotting disorder	☐ Easy bruising	☐ Anemia	☐ Enlarged lymph nodes ☐ History of blood clot

Are you currently <u>pregnant</u>? ☐ Yes