Please check one
[ ] Dr. Ben S. Wehrli
[ ] Dr. Douglas Croff

CVFA
COACHELLA VALLEY FOOT AND ANKLE

Patient Name (Last, MI., First): _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ **Cell Phone:** _____ **ALT#:** _____

Date of Birth: _____ **Gender:** ____ **Male** _____ **Female General Information: Height:** _____ **Weight:** _____

Patient's Social Security Number: _____ **Driver's License Number:** _____

Primary Physician: _____
How did you hear about Dr.Wehrli/Dr. Croff: Referred by: _____
Website or internet search: ____ Insurance:____ Friend or Family: ____ Phone Book: ____ Newspaper: ____
Community Lecture: ____ Other: _____

Employer/Occupation
Name of Employer: _____
Address: _____
Phone: _____

Emergency Contact
Name: _____ Address: _____
Relationship to Patient: _____ Phone: _____

Insurance Information

Primary Insurance Co. Name: _____ Address: _____
Phone: _____ INS ID/CERT#: _____
Subscriber's Name: _____ D.O.B. _____ SS#: _____

Insurance Card Carrier
Secondary Insurance Co. Name: _____ Address: _____
Phone: _____ INS ID/CERT#: _____
Subscriber's Name: _____ D.O.B. _____ SS#: _____

I agree that I am responsible for all professional services rendered by the physician despite insurance coverage. I also give consent to and authorize treatment for myself or any minor child that may be necessary in judgement of the physician and /or medical personnel.

Signature:_____ Date: _____

What brings you to our practice? (Chief complaint): (Please mark):

Ankle sprain/injury: ___ Ankle Swelling: ___ Ankle Popping: ____ Bunion: ____ Toe pain/Deformities: ____
Heel Pain: ____ Ingrown Nail: ___ Wart or other skin lesion: ____ Gout: ____ Flatfeet: ____
High arches: ____ Foot/Ankle Arthritis: ____ Athlete's Foot: ____ Nail Fungus: ____
Diabetic Foot Exam/Care: ___ Foot/Leg Wounds: ___ Rash on Leg/Feet: ___ Shin Splints: ___ Need Orthotics: ___ Painful bump: ____

Signs and Symptoms (Please mark):
Burning: ____ Numbness: ____ Pale toes or Feet: ___ White toes or feet: ____ Blue toes or feet: ____ Lump: ____ Pain: ____ Cramping: ____ Tingling: ____Cold toes or feet: ____ Hot toes or feet: ____ Soreness: ____
Toes bend in odd directions: ____ Swelling: ____ Chronic pain: ____ Skin changes: ____ Odor: ____ Excessive sweating: ____

How did this occur (Please mark):
Recent trauma: ____ Improper shoes: ____ Gradual onset: ____ Sudden onset: ____
Work related injury: ____ Previous issue/injury: ____
Please Explain: _____
_____

Duration of Symptoms: ____ Days: ___ Weeks: ____ Months: ____ Years: ____ Please Provide Additional Details Below:
_____
_____
_____

Have you seen other Physicians for this problem: Y ____ N ____ If so, what treatment was provided:
_____
_____
_____

Are you presenting for a second opinion: Y ____ N ____
Who referred you for a second opinion?
_____

MEDICAL HISTORY

MEDICATIONS
Name: _____ Dosage: _____ Frequency: _____ Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
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Name: _____ Dosage: _____ Frequency: _____

PLEASE INDICATE ANY MAJOR HEALTH PROBLEMS

Heart attack/disease: ____ Cancer: ____ Tumor: ____ Blood clots to extremities/lungs: ____
Diabetes: ____ High Blood pressure: ____ Respiratory problems: ____ Gastrointestinal: ____ Arthritis: ____
Other_____
_ _____
_____

ALLERGIES

Medications and type of reaction: _____
Medications and type of reaction: _____
Medications and type of reaction: _____
Reactions to Anesthesia: _____ Environmental or food: _____ Latex or Iodine: Y ____ N ____

SURGICAL HISTORY

Surgical Procedure:_____ Date:_____ Complications:_____
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Surgical Procedure:_____ Date:_____ Complications:_____
Surgical Procedure:_____ Date:_____ Complications:_____

REVIEW OF SYSTEMS

EYES, EARS, NOSE, THROAT

Have you previously had?:
Glaucoma: Y ____ N ____ Ear Infections: Y ____ N ____
Trouble with balance: Y ____ N ____ Tinnitus (ringing in ears): Y ____ N ____
Difficulty swallowing: Y ____ N ____

RESPIRATORY

Shortness of breath: Y ____ N ____
Do you require sleep aids for breathing: Y ____ N ____

SKIN

Have you previously had?:
Chronic skin infections: Y ____ N ____ Chronic wounds/ulcers: Y ____ N ____ Moles or skin marks that have change in size or color: Y ____ N ____

BREAST (Men and Women) Previous or existing lump/nodule: Y ____ N ____
Unusual Discharge: Y ____ N ____

GASTROINTESTINAL

Stomach pain, indigestion or heartburn: Y ____ N ____ Stomach or abdominal cramping: Y ____ N ____
Blood in stools or black stools: Y ____ N ____ Taking iron supplements: Y ____ N ____
Constipation: Y ____ N ____ Loose stools or diarrhea: Y ____ N ____
Recent changes in bowel habits: Y ____ N ____ Stomach, duodenal, or peptic ulcers: Y ____ N ____ Hepatitis or cirrhosis: Y ____ N ____ Gall bladder disease or pancreatitis: Y ____ N ____

CARDIOVASCULAR

Do you currently or have you recently had?:
Chronic cough: Y ____ N ____ Emphysema: Y ____ N ____ Chest pain: Y ____ N ____
Tuberculosis: Y ___ N ____ Pneumonia: Y ____ N ____ Coughing blood: Y ____ N ____
Blood clots: Y ____ N ____ Stroke: Y ____ N ____ Abnormal EKG: Y ____ N ____
Heart murmur: Y ____ N ____ High Blood pressure: Y ____ N ____ Varicose Veins: Y ____ N ____
Swelling of ankles or feet: Y ____ N ____ Previous heart attack or heart disease: Y ____ N ____ **ENDOCRINE**
Diabetes Type I: Y ____ N ____

Diabetes Type II: Y ____ N ____
Low Thyroid: Y ____ N ____
High thyroid: Y ____ N ____
Other endocrine disorders: Y ____ N ____

EXTREMTITES
Joint pain: Y ____ N ____
Leg cramping or burning while walking: Y ____ N ____
(If yes to above, how many blocks can you walk before experiencing discomfort?)_____
Blood clots in legs or arms: Y ____ N ____
(If yes to above, what type of treatment was required)

_____
Swelling of legs/feet/ankles: Y ____ N ____ Chronic wounds: Y ____ N ____

Hair loss in legs/feet: Y ____ N ____ Cold legs/feet: Y ____ N ____ Excessive sweating or heat in arms/hands or legs/feet: Y ____ N ____
Skin changes in legs/feet: Y ____ N ____

FAMILY HISTORY (Blood relatives including children)
Diabetes: Y ____ N ____ Heart disease: Y ____ N ____
Cancer, Leukemia, Hodgkin's disease: Y ____ N ____
Stroke: Y ____ N ____ Blood Clots or clotting disorders: Y ____ N ____ Anemia: Y ____ N ____
Kidney disease: Y ____ N ____ High blood pressure: Y ____ N ____
Other diseases:_____

SOCIAL
Do you or any of your children have any birth defects: Y ____ N ____
Do you exercise regularly: Y ____ N ____ Occupation: Y ____ N ____
Currently employed: Y ____ N ____ Disabled: Y ____ N ___
Special skills or hobbies: _____

_____

Do you?: Tobacco: Y ____ N ____
Drink alcohol: Y ____ N ____ If yes AMOUNT: _____
If yes AMOUNT: _____ FREQUENCY: _____
FREQUENCY: _____ (If previous smoker when did you last smoke?:_____)

Illicit drugs: Y ____ N ____ OTHER:
If yes AMOUNT: _____ If yes AMOUNT: _____
FREQUENCY:_____ FREQUENCY: _____
Are there any other medical problems not mentioned above?

_____
_____

We strive to coordinate your care and involve your other treating physicians. Please include the names of other health providers currently treating you.

Physician name: _____ Physician name: _____
Physician name: _____ Physician name: _____

For more information about our practice please visit us at www.coachellavalleyfootandankle.com