



Frederick J. Tomassi, DPM  
*Physician and Surgeon of the Foot & Ankle*  
Board Certified ABPOPPM

Dear Patient:

We would like to take this time to welcome you to our office. We will do all we can to make your visit a pleasant one.

We have enclosed several forms, which we ask you to complete in full. Once you have filled out all information, please bring them with you to your scheduled appointment.

**INSURANCE:** Insurance information must be filled out completely. If this information is not available at the time of your visit, you will be required to make payment on the date of service and all future visits. Please bring in your insurance cards as well. Copies will be made and kept in your chart, allowing prompt and accurate processing of your claim. As a courtesy, we will be happy to submit all claims to your insurer. Should your carrier refuse payment, you will be required to pay for all unpaid claims. All deductibles and balances are also the sole responsibility of the patient. Payment in full must be made within 30 days of the billing or a monthly surcharge of \$29.00 may be implemented unless other satisfactory arrangements are made.

**CO-PAY:** All co-pays are required prior to seeing the doctor.

**MANAGED CARE:** If a managed care provider covers you, you must first obtain a WRITTEN referral from your primary care physician. This written copy is requested at the time of all appointments. Usually primary care offices require TWO weeks advanced notice. If you do not have a copy of your validation, your appointment will need to be rescheduled for a later time. Remember: primary care offices do not permit "Back Dated" referrals.

**HISTORY FORMS:** Dr. Tomassi does not treat a toe, a nail, or a foot. He treats people. Please fill out all medical information. Please note the highlighted directions and read carefully. DO NOT WRITE IN yes or no under medical history check only those, which apply. Please check any yes or no response. Family history, social history and past surgeries are required information. PLEASE BRING IN A WRITTEN LIST OF ALL MEDICATIONS (prescription or otherwise) with dosage, amount per day, and the reason you take it.

**X-RAYS:** If applicable, please bring in any x-rays and written reports you may have at the time of your visit that pertains to your problems.

This letter has been created to hopefully alleviate any potential misunderstandings or miscommunications. Our office is always open to you for any questions or concerns you may have. We hope that your visit with us is a pleasant one. On behalf of Dr. Tomassi and staff, we thank you for your cooperation.



**AUTHORIZATION FOR TREATMENT AND  
RELEASE OF MEDICAL AND INSURANCE INFORMATION**

**AUTHORIZATION OF TREATMENT**

I the undersigned hereby authorize **Dr. Tomassi and/or his associate(s)** to render treatment and/or therapy to myself that he deems medically necessary in order to treat the condition and/or conditions I have requested from himself and his staff.

SIGNATURE OF PATIENT/GUARDIAN: \_\_\_\_\_

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: \_\_\_\_\_

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage w/ the enclosed captioned, and hereby assign and convey directly to **Dr. Tomassi and/or his associates** all medical benefits, insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor. I also permit full disclosure of my deductible, what has been met, if any, and what is currently owed. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments, and understand that these balances are due within 90 days from the date of insurance payment, and/or denial, and if outside collection attempts are necessary, I will also remain responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor any and all plan documents, insurance policy and/or settlement, information upon written request from such doctor, in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefit claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care coverage under any applicable insurance policies and/or employee health care plan w/ respect to medical expenses incurred as a result of the medical services I received from the above named doctor, and to the extent permissible under the law to claim such medical benefits, insurance reimbursement, and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate w/ such doctor in any attempts by such doctor to pursue such claim, chose in action or right against my insurers, and/or employee health care plan, including, if necessary, bring suit w/ such doctor against such insurers and/or employee health care plan in my name but at such doctor's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

\_\_\_\_\_  
SIGNATURE OF INSURED/GUARDIAN

\_\_\_\_\_  
DATE

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: \_\_\_\_\_

**I acknowledge that I received A Notice of Privacy.**

BayCity Associates in Podiatry Inc.

Dr. Tomassi

Dr. Olson

**I. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE**

- a) I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information.
- b) I have read and understand your Notice of Privacy Practices (effective April 14, 2003). I understand that this office may change its policy from time to time, and that I may request a current copy at any time.
- c) I understand that I may request in writing that you restrict how my private information is used and that this office can agree or disagree with my restriction request.

I hereby authorize this practice to disclose, both orally and in writing all facts pertaining to past, present, and future conditions, treatment(s), and services rendered, with no exceptions. This include diagnosis, prognosis, care and treatment, reports, testing, and changes. You may release information to the following people:

I understand that I may change this authorization in writing at any time.

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>TELEPHONE</u>
-------------	---------------------	------------------

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Patient Signature: \_\_\_\_\_ D.O.B. \_\_\_\_\_

If you are the personal representative of this person listed above, please check off the basis for you authority:

- 1. Power of Attorney (copy needed) \_\_\_\_\_
- 2. Guardianship (copy needed) \_\_\_\_\_
- 3. Parent of a minor \_\_\_\_\_
- 4. Other: \_\_\_\_\_

\* Witness signature for verbal consent and rank: \_\_\_\_\_  
Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE \_\_\_\_\_

SHOE SIZE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ Ft \_\_\_\_\_ In. WEIGHT: \_\_\_\_\_ Lbs.

I CHIEF COMPLAINT: Please be specific. "I am here today for \_\_\_\_\_  
\_\_\_\_\_

My area of pain is in or around: Not applicable. No pain \_\_\_\_\_.

Right: Foot \_\_\_\_\_ Ankle \_\_\_\_\_ Arch \_\_\_\_\_ Heel \_\_\_\_\_ Achilles Tendon (Heel Cord) \_\_\_\_\_

Toe(s) 1 2 3 4 5 Toenail(s) 1 2 3 4 5 Lower Leg \_\_\_\_\_

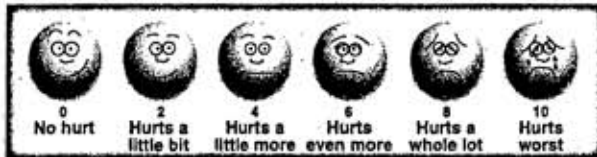
Left: Foot \_\_\_\_\_ Ankle \_\_\_\_\_ Arch \_\_\_\_\_ Heel \_\_\_\_\_ Achilles Tendon (Heel Cord) \_\_\_\_\_

Toe(s) 1 2 3 4 5 Toenail(s) 1 2 3 4 5 Lower Leg \_\_\_\_\_

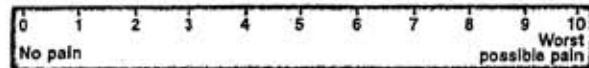
II My problem (if applicable) has been present for: \_\_\_\_\_ day(s) \_\_\_\_\_ week(s) \_\_\_\_\_ month(s) \_\_\_\_\_ year(s)

III I would rate my pain as: Use either scale.

Choose a face (from 0 to 10)



Choose a number (from 0 to 10)



IV I would describe my pain as: No pain \_\_\_\_\_ Dull \_\_\_\_\_ Sharp \_\_\_\_\_ Throb \_\_\_\_\_ Burn \_\_\_\_\_ Numb \_\_\_\_\_  
Tingling \_\_\_\_\_ Shooting \_\_\_\_\_ Deep \_\_\_\_\_ Other: \_\_\_\_\_

V Do you remember any trauma or incident which may have caused this? Unsure \_\_\_\_\_ No \_\_\_\_\_  
Yes: \_\_\_\_\_

VI Did the pain come on: Slowly \_\_\_\_\_ Suddenly \_\_\_\_\_

VII My pain is present in: AM \_\_\_\_\_ PM \_\_\_\_\_ Both \_\_\_\_\_ Varies \_\_\_\_\_

VIII My pain is: Constant \_\_\_\_\_ Intermittent \_\_\_\_\_ Transient \_\_\_\_\_ Worsening \_\_\_\_\_ Improving \_\_\_\_\_ Unchanged \_\_\_\_\_

IX I mostly notice my pain: When I bear weight \_\_\_\_\_ When I am off of my feet \_\_\_\_\_  
Both on and off my feet \_\_\_\_\_ With activity \_\_\_\_\_

X My pain: improves \_\_\_\_\_ worsens \_\_\_\_\_ remains unchanged \_\_\_\_\_ with my shoes on.

XI Does anything else make it feel better? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

XII Does anything else make it feel worse? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

XIII Treatment(s): None \_\_\_\_\_ I have tried: \_\_\_\_\_  
The treatment(s): Succeeded \_\_\_\_\_ Partially succeeded \_\_\_\_\_ Unsuccessful \_\_\_\_\_

XIV Have any Doctors treated this condition? No \_\_\_\_\_ Yes \_\_\_\_\_ Treatment: \_\_\_\_\_  
Succeeded \_\_\_\_\_ Partially succeeded \_\_\_\_\_ Unsuccessful \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
Age: \_\_\_\_\_

WE ARE PLEASED TO HAVE YOU AS A PATIENT. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. **WE TREAT PEOPLE, NOT FEET.**

- FAMILY PHYSICIAN?** No \_\_\_ Yes \_\_\_ Doctor's Name: \_\_\_\_\_  
Your last checkup by your doctor: Month \_\_\_ Year \_\_\_ Unknown \_\_\_  
Last COMPLETE history & physical: Month \_\_\_ Year \_\_\_ Unknown \_\_\_ Never \_\_\_
- Do you feel that you are in good, general health? No \_\_\_ Yes \_\_\_  
Do you feel that you heal well? No \_\_\_ Yes \_\_\_
- Female: To your knowledge, are you pregnant, planning pregnancy or nursing? No \_\_\_ Yes \_\_\_  
If yes, what month? \_\_\_\_\_

**MEDICAL HISTORY**

Please check (☑) **ANY** illnesses you have had IN THE PAST or NOW CURRENTLY HAVE:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS                        | <input type="checkbox"/> Glaucoma/Cataracts          | <input type="checkbox"/> Liver problems                            |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Lung problems                             |
| <input type="checkbox"/> Angina                      | <input type="checkbox"/> Heart problems (type) _____ | <input type="checkbox"/> Phlebitis: RT Leg ___ LT Leg ___ Both ___ |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Heart valve problems        | <input type="checkbox"/> Pneumonia                                 |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Rheumatic fever                           |
| <input type="checkbox"/> Cancer (type) _____         | <input type="checkbox"/> High cholesterol            | <input type="checkbox"/> Stomach ulcer/Hiatal hernia               |
| <input type="checkbox"/> Congestive heart failure    | <input type="checkbox"/> High lipids                 | <input type="checkbox"/> Stroke                                    |
| <input type="checkbox"/> Diabetes: Type I ___ II ___ | <input type="checkbox"/> HIV                         | <input type="checkbox"/> Tuberculosis                              |
| <input type="checkbox"/> Edema (swelling)            | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Vein / Artery disease                     |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Low blood pressure          | <input type="checkbox"/> Venereal disease                          |
| <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Kidney problems             |  |

**BLEEDING / SCARRING PROBLEMS** Please **CHECK** (☑) **NO** or **YES**

Transfusions:  No  Yes Year \_\_\_\_\_ Reason \_\_\_\_\_

Bruise easily  No  Yes Clotting problems  No  Yes  
Scar poorly  No  Yes Sickle cell disease/trait  No  Yes

**CHILDHOOD ILLNESSES** Please check (☑)

- |  |   |  |                             |
|--|---|--|-----------------------------|
| <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Measles                  | <input type="checkbox"/> Mumps         | <input type="checkbox"/> TB |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Rubella (German measles) | <input type="checkbox"/> Scarlet fever |                             |

To my knowledge, all immunizations are up to date:  No  Yes

**ALLERGIES/REACTIONS TO THE FOLLOWING:** Please check (☑) and indicate reaction.

I have no known drug allergies \_\_\_\_\_.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergens _____ | <input type="checkbox"/> Foods _____      | <input type="checkbox"/> Sedatives _____      |
| <input type="checkbox"/> Aspirin _____   | <input type="checkbox"/> Ibuprofen _____  | <input type="checkbox"/> Sleeping pills _____ |
| <input type="checkbox"/> Bee sting _____ | <input type="checkbox"/> Iodine _____     | <input type="checkbox"/> Steroids _____       |
| <input type="checkbox"/> Chemicals _____ | <input type="checkbox"/> Latex _____      | <input type="checkbox"/> Sulfa _____          |
| <input type="checkbox"/> Clothing _____  | <input type="checkbox"/> Morphine _____   | <input type="checkbox"/> Tape _____           |
| <input type="checkbox"/> Codeine _____   | <input type="checkbox"/> Motrin _____     | <input type="checkbox"/> Tylenol _____        |
| <input type="checkbox"/> Cortisone _____ | <input type="checkbox"/> Nickel _____     | <input type="checkbox"/> Valium _____         |
| <input type="checkbox"/> Demerol _____   | <input type="checkbox"/> Novocaine _____  | <input type="checkbox"/> X-ray dye _____      |
| <input type="checkbox"/> Eggs _____      | <input type="checkbox"/> Penicillin _____ |   |

OTHER: (Metals, Prednisone, Antibiotics, Pain killers, Anti-inflammatory)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATIONS**

- \* No prescription medications at this time: \_\_\_\_\_
- \* If you are taking **MORE THAN 5** prescription medications please use a **SEPARATE** piece of paper. The medications, its amount (milligrams, micrograms, etc.), how often it is taken, and what illness it is used for **MUST BE INCLUDED.**

<u>NAME OF DRUG</u>	<u>DOSAGE</u>	<u>ILLNESS IT IS USED FOR</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

**FEMALES:** Please list your prescription birth control medications if taken.

- A) Birth Control Injection \_\_\_\_\_ B) Birth Control Pills \_\_\_\_\_
- C) Birth Control Implant (Norplant) \_\_\_\_\_ Other. \_\_\_\_\_
- NO BIRTH CONTROL PILL \_\_\_\_\_

**OVER-THE-COUNTER MEDICATIONS**

•The following over-the-counter (OTC) substances affect the blood's ability to clot. Have you taken **ANY** of the following in the **last two weeks**: Please check (☑)

- Aspirin: 81 mg \_\_\_ 325 mg \_\_\_ 500 mg \_\_\_ Taken \_\_\_ times per day \_\_\_ as needed
- Ibuprofen: 200 mg Taken \_\_\_ times per day \_\_\_ as needed
- Excedrin Taken \_\_\_ times per day \_\_\_ as needed
- Vitamin E \_\_\_\_\_ IU Taken \_\_\_ times per day \_\_\_ as needed
- St. John's wort \_\_\_\_\_ mg Taken \_\_\_ times per day \_\_\_ as needed
- Garlic Taken \_\_\_ times per day \_\_\_ as needed
- Ginseng Taken \_\_\_ times per day \_\_\_ as needed
- Other herbal/natural supplements: \_\_\_\_\_

**PRIOR SURGERY (S)** (Check only those items that apply.)

I have **NEVER** had surgery, and I still have my tonsils. \_\_\_\_\_

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Angioplasty       | <input type="checkbox"/> D and C       | <input type="checkbox"/> Tonsillectomy   | <input type="checkbox"/> Endoscopy      | <input type="checkbox"/> Appendectomy    |
| <input type="checkbox"/> Prostate surgery  | <input type="checkbox"/> Heart cath    | <input type="checkbox"/> C-section       | <input type="checkbox"/> Mastectomy     | <input type="checkbox"/> Venous ligation |
| <input type="checkbox"/> Neck surgery      | <input type="checkbox"/> Cataract      | <input type="checkbox"/> Kidney stone sx | <input type="checkbox"/> Breast biopsy  | <input type="checkbox"/> Foot surgery    |
| <input type="checkbox"/> Carotid artery sx | <input type="checkbox"/> Hysterectomy  | <input type="checkbox"/> Kidney removal  | <input type="checkbox"/> Breast surgery |  |
| <input type="checkbox"/> Gall bladder sx   | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Colonoscopy     |   |  |

Other surgery (please list) \_\_\_\_\_

Did you have **ANY** adverse reactions to **ANESTHESIA** or **MEDICATIONS** before, during, or after your surgery? No \_\_\_ Yes \_\_\_

Did you have **ANY COMPLICATIONS** with healing? No \_\_\_ Yes \_\_\_

Complication(s): \_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**FAMILY HISTORY**

If **ANY** of your relatives in the column below currently **HAS** or **PASSED AWAY** from the following illnesses, please **WRITE IN** the correct cause of death.

- Not applicable: Adopted \_\_\_\_\_.

ARTHRITIS    DIABETES    HEART DISEASE    KIDNEY DISEASE    THYROID  
 CANCER (type) \_\_\_\_\_    GOUT    HIGH BLOOD PRESSURE    STROKE    OTHER

<b><u>FAMILY MEMBER</u></b>	<b><u>Alive</u></b>	<b><u>Deceased</u></b>	<b><u>Cause of death</u></b>	<b><u>Age at passing</u></b>
Your Mother	A	D		
Your Father	A	D		
Grandmother (Mom's)	A	D		
Grandfather (Mom's)	A	D		
Grandmother (Dad's)	A	D		
Grandfather (Dad's)	A	D		
Sister(s) – Brother(s)	A	D		

**SOCIAL HISTORY** (☑)

Marital Status:    M \_\_\_ S \_\_\_ D \_\_\_ Legally Separated \_\_\_ Widow(er) \_\_\_

Smoking  No  Yes Packs per day \_\_\_\_\_ How long? \_\_\_\_\_ Quit  No  Yes When? \_\_\_\_\_  
 Pipe  Cigar  Chew/Snuff    Is there smoking in the house:  No  Yes

Alcohol  No  Yes #of beers/ wk. \_\_\_\_\_ Wine # of glasses/wk \_\_\_\_\_ # of drinks/wk. \_\_\_\_\_  
 Social  Quit    Number of months \_\_\_\_\_ Years \_\_\_\_\_

Caffeine  No  Yes Coffee \_\_\_ Tea \_\_\_ Energy/Diet \_\_\_ Pop \_\_\_ Other: \_\_\_ Cups/day \_\_\_

Exercise  No  Yes Infrequently \_\_\_ Regularly \_\_\_ Type \_\_\_\_\_

Recreational drugs  Never  Current usage Type \_\_\_\_\_  
 Quit Date: \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_ Rehab  No  Yes # of Times \_\_\_\_\_

**OCCUPATIONAL HISTORY** (☑)

Job Title(Be specific): \_\_\_\_\_ Full-time \_\_\_ Part-time \_\_\_ Homemaker: \_\_\_ Retired: \_\_\_

Past/Present Industrial/Agricultural/Chemical exposure  No  Yes Protective equipment worn  No  Yes

Percentage of your day you stand and/or walk 0 \_\_\_ 20 \_\_\_ 40 \_\_\_ 50 \_\_\_ 60 \_\_\_ 80 \_\_\_ 100 \_\_\_

**INJURIES/TRAUMA** (☑)

Automobile accident \_\_\_ Fracture(s) \_\_\_ Dislocation(s) \_\_\_ Lacerations \_\_\_ Burns \_\_\_ Blunt trauma \_\_\_  
 Please describe above positive responses: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**•GENERAL MEDICAL QUESTIONS**1. Do you have ANY vascular grafts (i.e., bypasses)? Please check (✓)

<input type="checkbox"/> Heart	Date: _____	Complications? _____
<input type="checkbox"/> Aorta	Date: _____	Complications? _____
<input type="checkbox"/> Femoral	Date: _____	Complications? _____
<input type="checkbox"/> Other	Date: _____	Complications? _____

2. Have you had ANY heart valve replacements or repair?  No  Yes Date: \_\_\_\_\_

Complications? \_\_\_\_\_

Have you had ANY stents?  No  Yes Date: \_\_\_\_\_Do you have a pacemaker?  No  Yes Date: \_\_\_\_\_

Complications? \_\_\_\_\_

3. Do you have ANY artificial joints?  No  Yes If so where?

<input type="checkbox"/> Hips	RT ___ LT ___ Both ___	Date: _____
<input type="checkbox"/> Knees	RT ___ LT ___ Both ___	Date: _____
<input type="checkbox"/> Shoulders	RT ___ LT ___ Both ___	Date: _____
<input type="checkbox"/> Toes	RT ___ LT ___ Both ___	Date: _____
<input type="checkbox"/> Fingers	RT ___ LT ___ Both ___	Date: _____

4. Are you currently under active chemotherapy?  No  Yes

If so, type of cancer \_\_\_\_\_

What type of treatment? Radiation \_\_\_ Chemical \_\_\_ Oral \_\_\_ Other \_\_\_

Last treatment date: \_\_\_\_\_

Next scheduled treatment date: \_\_\_\_\_

5. Are you diabetic?  No  Yes

Insulin-Dependant \_\_\_

Non-Insulin Dependant \_\_\_

Both \_\_\_ Diet regulated only \_\_\_

6. Are you currently undergoing dialysis?  No  Yes

If so, how often do you take it? \_\_\_\_\_ x per week.

Days:  Mon  Tues  Wed  Thur  Fri  Sat

Where is it given? \_\_\_\_\_

7. Do you have a weakened immune system?  No  Yes

If yes:

 Alcohol  Drug problems  Low white blood cells AIDS  HIV Transplant medications due to major organ(s) transplant(s).

Organ(s) transplanted: \_\_\_\_\_

8. History of blood clots?  No  Yes

Location of clots: \_\_\_\_\_

Treatment(s) given: \_\_\_\_\_

Year of occurrence: \_\_\_\_\_

I, the undersigned, understand that the above information is necessary to provide me with the best medical care in a safe, efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Caregiver, Parent, or Guardian if applicable.)

**REVIEW OF SYSTEMS (You must circle a Y or N)**

<b>I General</b>	<u>Now</u>	<u>Past</u>
Weight Change	Y N	Y N
Chills	Y N	Y N
Sleep Disorder	Y N	Y N
Other: _____		

<b>VIII Skin</b>	<u>Now</u>	<u>Past</u>
Rash/Hives	Y N	Y N
Mole Changes	Y N	Y N
Skin Cancers	Y N	Y N
Thick Nails	Y N	Y N
Other: _____		

<b>II Eyes</b>	<u>Now</u>	<u>Past</u>
Double Vision	Y N	Y N
Cataracts	Y N	Y N
Glaucoma	Y N	Y N
Glasses/Contacts	Y N	Y N
Other: _____		

<b>IX Kidneys</b>	<u>Now</u>	<u>Past</u>
Prostate Problems	Y N	Y N
Pain with Urination	Y N	Y N
Nite Time Urination	Y N	Y N
Pain/Burn with Urination	Y N	Y N
Other: _____		

<b>III Ears/Nose/Throat</b>	<u>Now</u>	<u>Past</u>
Hearing Problems	Y N	Y N
Balance Problems	Y N	Y N
Smell Disorder	Y N	Y N
Sore Throats	Y N	Y N
Other: _____		

<b>X Lungs</b>	<u>Now</u>	<u>Past</u>
Pain with Breathing	Y N	Y N
Shortness of Breath	Y N	Y N
Asthma/Emphysema	Y N	Y N
Persistent Cough	Y N	Y N
Other: _____		

<b>IV Cardiovascular</b>	<u>Now</u>	<u>Past</u>
Hi Blood Pressure	Y N	Y N
Heart Valve Problems	Y N	Y N
Chest Pain	Y N	Y N
Irregular Beat	Y N	Y N
Other: _____		

<b>XI Stomach</b>	<u>Now</u>	<u>Past</u>
Ulcer/GERD	Y N	Y N
Abdominal Pain	Y N	Y N
Nausea/Vomit	Y N	Y N
Heartburn/Irritable Bowel	Y N	Y N
Other: _____		

<b>V Endocrine</b>	<u>Now</u>	<u>Past</u>
Diabetes	Y N	Y N
Thyroid Hi	Y N	Y N
Thyroid Low	Y N	Y N
Too Hot/Cold	Y N	Y N
Other: _____		

<b>XII Circulation</b>	<u>Now</u>	<u>Past</u>
Leg Cramps while walking	Y N	Y N
Cramps in Bed	Y N	Y N
Blood Clots	Y N	Y N
Vein Problems	Y N	Y N
Other: _____		

<b>VI Blood/Lymph</b>	<u>Now</u>	<u>Past</u>
Clotting Problems	Y N	Y N
Bruise easy	Y N	Y N
Swollen Glands	Y N	Y N
Transfusion	Y N	Y N
Other: _____		

<b>XIII Nerves</b>	<u>Now</u>	<u>Past</u>
Seizures/Strokes	Y N	Y N
Mini Strokes	Y N	Y N
Numbness/ Tingling	Y N	Y N
Dizzy Spells	Y N	Y N
Other: _____		

<b>VII Musculoskeletal</b>	<u>Now</u>	<u>Past</u>
Bone Pain	Y N	Y N
Joint Pain	Y N	Y N
Sprain/Strain	Y N	Y N
Other: _____		

<b>XIV Psychologic</b>	<u>Now</u>	<u>Past</u>
Anxious/Depressed	Y N	Y N
BiPolar/Obs.comp.	Y N	Y N
Other: _____		

\* Positive ROS responses not related to the podiatric problem(s) have been discussed with the patient. The patient has been advised to see their PCP.

Dr. Tomassi \_\_\_\_\_

Dr. Olson \_\_\_\_\_

## PATIENT SURVEY

1. Are you presently taking any type of nutritional supplements (such as vitamins, minerals, herbs, amino acids, fish oils, etc)?  
 yes  
 no
  
2. Name the supplements that you are presently taking:
  
  
3. Who recommended you take these supplements?  
 family member or friend  
 advertisement  
 health professional  
 other
  
4. Where did you purchase these supplements?  
 mail-order  
 nutrition or vitamin shop  
 pharmacy  
 healthcare provider  
 other
  
5. If your doctor offered an advanced, high quality line of supplements, would you consider purchasing them?  
 yes  
 no
  
6. If your doctor offered a simple genetic test to determine what supplemental regimen is best for you, based on your genetic variations, would you consider doing it?  
 yes  
 no
  
7. If this office offered a comprehensive weight management program, would you consider it?  
 yes  
 no
  
8. If this practice offered a nutrition education program to improve your dietary habits, would you consider it  
by appointment with one of our staff?  yes  no  
by a class exclusively for our patients?  yes  no