BAY CITY

Associates in Podiatry, Inc.

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 all to your scheduled appointment.

INSURANCE: Please bring in your insurance cards. Copies will be made and kept in your chart which allows for 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 are also the sole responsibility of the patient. Payment in full must be made within 30 days of the billing or a surcharge of $29.00 may be implimented unless other satisfactory arrangements are made. We do offer payment plans.

COPAYS: All copays are required prior to seeing the doctor; which is dictated by your insurance company per your contractual agreement with your insurance carrier.

MANAGED CARE: If your insurance requires a referral from your Primary Care Physician, that is your responsibility. We do not obtain referrals for you.

HISTORY FORMS: We do not treat a toe, a nail or a foot. We treat people. Please fill out all medical information. Please note the highlighted areas 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 - PRESCRIPTIONS OR OVER THE COUNTER. Include the 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 problem.

THis letter has been created to 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. Olson, Dr. Tomassi, Dr. Hess, Dr. Pokabla and staff, we sincerely thank you.

BayCity Associates in Podiatry, Inc.
3850 Walker Blvd.
Erie, PA 16509-1627
Phone 814-864-2360
Fax 814-864-2383

UNDERSTANDING DEDUCTIBLES, COINSURANCEAND COPAYS

When both you and your health insurance company pay for your health care expenses, it's called cost sharing. Deductibles, coinsurance and copays are all examples of cost sharing. Understanding how they work will help you know how much you'll pay.

Deductible

A deductible is the amount you pay for healthcare services before your health insurance begins to pay.

How it works: If your plan's deductible is $1,500, you'll pay 100 percent of eligible healthcare expenses until the bill's total $1,500. After that, you share the cost with your plan by paying coinsurance.

Coinsurance

Coinsurance is your share of the costs of healthcare service after your deductible has ben met.

How it works: You've paid $1,500 in healthcare expenses and met your deductible. When you go to the doctor, instead of paying all costs, you and your plan share the cost. For example, your plan pays 70 percent. The 30 percent you pay is your coinsurance.

Copay

A copay is a fixed amount you pay for a healthcare service, usually when you receive the service.

How it works: Your plan determines what your copay is for different types of services, and when you have one. You may have a copay before you've finished paying toward your deductible. You may also have a copay after you pay your deductible, and when you owe coinsurance.

Your insurance card may list copays for some visits.

BAYCITY ASSOCIATES IN PODIATRY, INC.

PATIENT INFORMATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (Last-First-Middle) ☐ Mr. ☐ Mrs. ☐ Miss | DATE OF BIRTH / / | AGE | MARITAL STATUS ☐S ☐M ☐D ☐SEP. | TODAY'S DATE / /

NAME | HOME PHONE ( )

ADDRESS (Street, City, State, Zip) | CELL ( )

SOCIAL SECURITY NO.

NAME OF EMPLOYER | OCCUPATION | WORK PHONE ( ) | EXTENSION

EMPLOYER ADDRESS (Street, City, State, Zip) | YRS EMPLOYED | WORK STATUS ☐ Full Time ☐ Retired ☐ 1st Shift ☐ 2nd Shift ☐ Part Time ☐ Not Employed ☐ 3rd Shift ☐ Varies

SPOUSE'S NAME (Last, First, Middle) | DATE OF BIRTH / / | NAME OF EMPLOYER | WORK PHONE ( )

OCCUPATION

PHARMACY NAME | ADDRESS | PHONE NO.

NEAREST FRIEND NOT LIVING WITH YOU | PHONE NO. ( ) | NEAREST RELATIVE NOT LIVING WITH YOU | PHONE NO. ( )

IN CASE OF EMERGENCY CONTACT | NAME | RELATIONSHIP | PHONE NO. ( )

WHO MAY WE THANK FOR REFERRING YOU TO US? | FAMILY PHYSICIAN | PHONE NO. ( ) | FAMILY DENTIST | PHONE NO. ( )

BayCity Associates in Podiatry, Inc.

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INSURANCE INFORMATION.

AUTHORIZATION OF TREATMENT

I the undersigned hereby authorize BayCity Physicians to render treatment / therapy to myself deemed medically necessary in order to treat the condition / 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 or employee healthcare benefits coverage with the enclosed captioned, and hereby assign and convey directly to **BayCity Associates, Inc.** all medical benefits, insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor. I also admit 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 collections 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 any administrator or fiduciary, insurer, and my attorney to release to such doctor, any and all plan documents, insurance policy / settlement, information upon written request from such doctor, in order to claim such medical benefits, reimbursements or any applicable remedies. I authorized the use of this signature on all my insurance / employee health benefit claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under any applicable insurance policies / employee healthcare plan to and claim, chose in action, or other right I may have to such insurance / employee healthcare coverage under my applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I recieved 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 with such doctor in any attempts by such doctor to persue such claim, chose in action or right against my insurers / employee health care plan, including, if necessary, bring suit with such doctor against such insurers / employee healthcare 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 HAVE RECEIVED **A NOTICE OF PRIVACY.**

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understands the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name:_____ Phone or other identifier:_____

Print Name:_____ Phone or other _____

III. Request to receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home telephone number:

___ ok to leave a message with detailed information -OR- ___ Leave message with call back number only

Work telephone number:

___ ok to leave a message with detailed information -OR- ___ Leave message with call back number only

Cell telephone number:

___ ok to leave a message with detailed information -OR- ___ Leave message with call back number only

Fax telephone number:

___ ok to fax to number listed here:_____

Email:

ok to email address Practice has on file

****

1. The above authorizations are voluntary and I may refuse their terms without affecting any of my rights to receive healthcare at the Practice.
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer".
3. The revocation of this authorization wil not have any effect on disclosures occurring prior to the execution of any revocation.
4. If you request it, a copy of the information described in this form can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (PRINTED)	Signature of Patient	Date

PATIENT NAME_____DATE_____

SHOE SIZE_____ HEIGHT_____Ft_____In WEIGHT_____Lbs

I. CHIEF COMPLAINT: Please be specific "I am here today for_____
_____

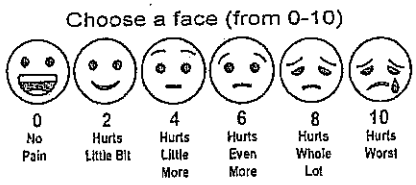
My area of pain is in or around: Not applicable__ No pain__

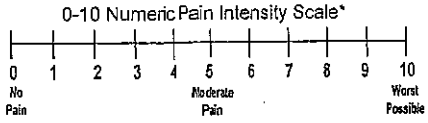
Right: Foot___ Ankle___ Arch___ Heel___ Achilles Tendon (Heel Cord) ___
Toe(s) 1 2 3 4 5 Toenail(s) 1 2 3 4 5 Lower Leg ___

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.





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.**

1. **FAMILY PHYSICIAN?** No____ Yes____ Doctor's Name:_____
   Your last checkup by your doctor: Month____ Year____ Unknown____
   Last *COMPLETE* history & physical: Month____Year____ Unknown____ Never____
2. Do you feel that you are in good, general health? No____ Yes____
   Do you feel that you heal well? No____ Yes____

MEDICAL HISTORY

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

- ☐ AIDS
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (type)_____
- ☐ Congestive Heart Failure
- ☐ Diabetes: Type I_____ Type II_____
- ☐ Edema (swelling)
- ☐ Emphysema
- ☐ Epilepsy / seizures
- ☐ Glaucoma / Cataracts
- ☐ Gout
- ☐ Heart problems (type) _____
- ☐ Heart valve problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Lipids
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Phlebitis; RT Leg__ LT Leg__ Both__
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stomach Ulcer/Hiatal Hernia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vein/Artery Disease
- ☐ Venereal Disease

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 (☑)

- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ TB
- ☐ Rheumatic Fever
- ☐ Rubella (German Measles)
- ☐ Scarlet Fever

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

ALLERGIES / REACTIONS TO THE FOLLOWING: Please Check (☑) and indicate reaction

I have no drug allergies_____

- ☐ Allergens _____
- ☐ Aspirin _____
- ☐ Bee Sting _____
- ☐ Chemicals _____
- ☐ Clothing _____
- ☐ Codeine _____
- ☐ Cortisone _____
- ☐ Demerol _____
- ☐ Eggs _____
- ☐ Foods _____
- ☐ Ibuprofen _____
- ☐ Iodine _____
- ☐ Latex _____
- ☐ Morphine _____
- ☐ Motrin _____
- ☐ Nickel _____
- ☐ Novocain _____
- ☐ Penicillin _____
- ☐ Sedatives _____
- ☐ Sleeping Pills _____
- ☐ Steroids _____
- ☐ Sulfa _____
- ☐ Tape _____
- ☐ Tylenol _____
- ☐ Valium _____
- ☐ X-Ray Dye _____

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

CURRENT PRESCRIPTION MEDICATIONS

*No prescription medications at this time: _____
*If you are taking **MORE THAN 5** 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**.

NAME OF DRUG	DOSAGE	ILLNESS IT IS USED FOR
1.		
2.		
3.		
4.		
5.		
6.		

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

A) Birth Control Injection _____ B) Birth Control Pills _____
C) Birth Control Implant (Norplant, Nexplanon) _____ Other _____
NO BIRTH CONTROL _____
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: 81mg_____ 325mg_____ 500mg_____	Taken____ times per day____ as needed
☐ Ibuprofen: 200mg	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 the items that apply)
I have **NEVER** had surgery and I still have my tonsils_____

☐ Angioplasty	☐ D and C	☐ Tonsillectomy	☐ Endoscopy	☐ Venous Ligation
☐ Prostate Surgery	☐ Heart Cath	☐ C-Section	☐ Mastectomy	☐ Foot Surgery
☐ Neck Surgery	☐ Cataract	☐ Kidney Stone sx	☐ Breast Biopsy	
☐ Carotid Artery sx	☐ Hysterectomy	☐ Kidney Removal	☐ Breast Surgery	
☐ Gall Bladder sx	☐ Hernia Repair	☐ Colonoscopy	☐ Appendectomy	

Other surgery(s) (please list) _____
Did you have **ANY** adverse reactions to **Anesthesia** or **Medications** before, during or after surgery? No____ Yes____
Did you have **ANY COMPLICATIONS** with healing? No____ Yes____
Complications_____
_____

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

Please circle the following answers

FAMILY MEMBER	Alive	Deceased	Cause of death	Age at passing
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 Seperated____ 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 that you stand / walk? 0___20___40___50___60___80___100___

INJURIES / TRAUMA (☑)

Automobile accident____Fracture(s)____Dislocation(s)____Laceration(s)____Burn(s)____Blunt trauma_____

Name_____ Date_____

GENERAL MEDICAL QUESTIONS

1. Do you have ANY vascular grafts (i.e. bypasses)? Please check (☑)

☐ Heart	Date:___/___/___	Complications? _____
☐ Aorta	Date:___/___/___	Complications? _____
☐ Femoral	Date:___/___/___	Complications? _____
☐ 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?_____

☐ Hips	RT___LT___ Both___	Date:___/___/___
☐ Knees	RT___LT___ Both___	Date:___/___/___
☐ Shoulders	RT___LT___ Both___	Date:___/___/___
☐ Toes	RT___LT___ Both___	Date:___/___/___
☐ 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? Date:___/___/___

   Next scheduled treatment.date? 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 cots? ☐ No ☐ Yes

   Location of clots: _____

   Treatment(s) given: _____

I, the undersigned, understand that the above information is neccessary 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's signature: _____ Date:___/___/___
(Caregiver, Parent or Guardian, if applicable)

Name: _____ Date: _____

REVIEW OF SYSTEMS (You MUST circle a Y OR N)

I	General	Now	Past
	Weight Change	Y N	Y N
	Chills	Y N	Y N
	Sleep Disorder	Y N	Y N
	Other_____		

II	Eyes	Now	Past
	Double Vision	Y N	Y N
	Cataracts	Y N	Y N
	Glaucoma	Y N	Y N
	Glasses/Contacts	Y N	Y N
	Other_____		

III	Ears/Nose/Throat	Now	Past
	Hearing Problems	Y N	Y N
	Balance Problems	Y N	Y N
	Smell Disorder	Y N	Y N
	Sore Throat	Y N	Y N
	Other_____		

IV	Cardiovascular	Now	Past
	High 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_____		

V	Endocrine	Now	Past
	Diabetes	Y N	Y N
	Thyroid High	Y N	Y N
	Thyroid Low	Y N	Y N
	Too Hot/Too Cold	Y N	Y N
	Other_____		

VI	Blood/Lymph	Now	Past
	Clotting Problems	Y N	Y N
	Bruise Easy	Y N	Y N
	Swollen Glands	Y N	Y N
	Transfusion	Y N	Y N
	Other_____		

VII	Musculoskeletal	Now	Past
	Bone Pain	Y N	Y N
	Joint Pain	Y N	Y N
	Sprain/Strain	Y N	Y N
	Other_____		

VIII	Skin	Now	Past
	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_____		

IX	Kidneys	Now	Past
	Prostate Problems	Y N	Y N
	Pain with Urination	Y N	Y N
	Night Time Urination	Y N	Y N
	Pain/Burn with Urination	Y N	Y N
	Other_____		

X	Lungs	Now	Past
	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_____		

XI	Stomach	Now	Past
	Ulcer/GERD	Y N	Y N
	Abdominal Pain	Y N	Y N
	Nausea/Vomiting	Y N	Y N
	Heartburn/Irritable Bowel	Y N	Y N
	Other_____		

XII	Circulation	Now	Past
	Leg Cramps	Y N	Y N
	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_____		

XIII	Nerves	Now	Past
	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_____		

*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.