MELCHIOR P. VALLONE, D.P.M.

Diplomate American Board of Podiatric Surgery
Podiatrist ~ Specialist in Foot Disorders

5129 Garfield Street ~ La Mesa, CA 91941
Phone Number: (619) 465-3200
Fax: (619) 465-3700

LAST **FIRST** **M.I.** **NAME:**			
STREET **ADDRESS:**			
CITY **STATE** **ZIP CODE** **CITY/STATE:**			
HOME PHONE NUMBER: ( )	**CELL PHONE NUMBER: ( )**	**DATE OF BIRTH:**	**AGE:**
SOCIAL SECURITY NUMBER:	**MARITAL STATUS: M /S / W / D**	**MALE / FEMALE**	**EMAIL ADDRESS:**
EMPLOYER:	**OCCUPATION:**	**BUSINESS PHONE NUMBER:**	
SPOUSE NAME:	**SOCIAL SECURITY NUMBER:**	**EMPLOYER:**	
PARTY RESPONSIBLE FOR PAYMENT ON ACCOUNT:		**RELATIONSHIP TO PATIENT:**	
WHOM MAY WE THANK FOR REFERRING YOU?			
PRIMARY INSURANCE COMPANY:		**COPAY:**	
SECONDARY INSURANCE COMPANY:			
WHAT IS YOUR FOOT COMPLAINT/PROBLEM TODAY?			

I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO BE AWARE OF MY INSURANCE COVERAGE, BENEFITS, AND PLAN. I WILL INFORM THE OFFICE OF ANY INSURANCE CHANGES IMMEDIATELY. IF I MISINFORM THE OFFICE REGARDING MY INSURANCE, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED - NO EXCEPTIONS.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS BY MY INSURANCE COMPANY TO BE MADE DIRECTLY TO DR. MELCHIOR P. VALLONE, DPM, FOR SERVICES RENDERED. MY BILL IS DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. MY COPAYMENTS ARE DUE BEFORE SERVICES ARE RENDERED. I ALSO ACKNOWLEDGE THAT DR. VALLONE WILL BILL MY INSURANCE COMPANY AS A COURTESY TO ME, BUT IT IS MY RESPONSIBILITY TO PROMPTLY PAY ANY PART OF THE BILL THAT IS NOT COVERED OR IS APPLIED TO MY DEDUCTIBLE.

I HEREBY GIVE MY PERMISSION TO DR. VALLONE TO EXAMINE, PHOTOGRAPH, ADMINISTER TREATMENT, AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT PROBLEM.

DATE: **SIGNATURE:**

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Today's Date: _____

Patient's First Name: _____ Patient's Last Name: _____

Reason for today's visit: _____

_____

Date of last podiatric exam: _____ By whom: _____

What is your main concern about your legs/feet? _____

_____

Which foot is bothering you? □ Left □ Right For how long? _____

Do you wear orthotics? □ Yes □ No If yes, how old are they? _____

What have you done to treat the problem yourself? _____

MEDICAL HISTORY

Primary Care Provider Name: _____ Dr's Phone # _____

*******Date You Last Saw Your Primary Care Provider?** _____

Are you currently taking any medications? (Including over the counter, herbs, contraceptives) □ Yes □ No

If yes, please list:

Medication Name	Dosage	Reason For Taking

Please use other side of paper to continue if needed.

Do you have any allergies to medications? □ Yes □ No If yes, please list:

Allergy/Medication Name	Reaction Details (Hives, Rash, Shortness of Breath, Anaphylactic)

Are you pregnant or nursing? □ Yes □ No

Please list your height in inches: _____ Your weight in pounds: _____

Check any of the following podiatry conditions you have had:

□Flat Feet	□Ankle Problems	□Bunions	□Hammer Toes`	□Diabetic Ulcers	□Fracture
□Neuroma	□Fungus	□Warts	□Ingrown Toenail	□Callouses	□Heel Pain
□Athletes Foot	□Itching	□Foot Odor	□Swelling		

Check any of the following medical conditions you have had:

□Pneumonia	□Arthritis/Gout	□Nervous Disorder	□Stroke
□Epilepsy	□High/Low Blood Pressure	□Diabetes	□Skin Disease
□Varicose Veins	□Keloid (scar) Formation	□Anemia	□Cancer/Tumors
□Hay Fever/Asthma	□Blood clots	□Frequent Colds/Sore Throat	□Bone Disease
□Bleeding Tendencies	□HIV/AIDS	□Liver Disease	□Swollen Feet/Ankles
□Tuberculosis	□Hepatitis		

Please explain if any of the above boxes are checked: _____

_____

_____

FAMILY MEDICAL HISTORY

Please note any family (parents, grandparents, siblings) for the following:

Disease/Condition	Yes / No / ?	Relationship to you
Bunions	□Yes □No □?	_____
Flat Feet	□Yes □No □?	_____
Hammertoes	□Yes □No □?	_____
High Arches	□Yes □No □?	_____
Skin Disease	□Yes □No □?	_____
Varicose Veins	□Yes □No □?	_____
Arthritis	□Yes □No □?	_____
Cancer/Tumor	□Yes □No □?	_____
Diabetes	□Yes □No □?	_____
Heart Trouble	□Yes □No □?	_____
High/Low Blood Pressure	□Yes □No □?	_____
Kidney Disease	□Yes □No □?	_____
Lupus	□Yes □No □?	_____
Thyroid Disease	□Yes □No □?	_____
Other	□Yes □No □?	_____

IMMUNIZATION STATUS
Please note history for the following:

Vaccine	Immunization Date
Tetanus	_____
Influenza	_____
Other	_____

SOCIAL HISTORY
This information is kept strictly confidential. However, you may choose to discuss this portion directly with the doctor if you prefer. □ Yes, I would prefer to discuss my Social History with the doctor.

Smoking Status: □Current everyday smoker □Current some day smoker □Former smoker □Never Smoker

Do you use tobacco products:	□yes □no	If yes, type/amount/how long: _____
Do you use illegal drugs?	□yes □no	If yes, type/amount/how long: _____
Do you consume alcohol?	□yes □no	If yes, type/amount/how long: _____

REVIEW OF SYSTEMS
Do you currently, or have you ever had any problems in the following areas:

Constitutional		Vascular/Cardiovascular	
Fever, Weight Loss/Gain	□Yes □No □?	Diabetes	□Yes □No □?
Integumentary (skin)		Heart/chest Pain	□Yes □No □?
Ulcers/wounds	□Yes □No □?	High Blood Pressure	□Yes □No □?
Neurological		Vascular Disease	□Yes □No □?
Headaches	□Yes □No □?	Gastrointestinal	
Migraines	□Yes □No □?	Diarrhea	□Yes □No □?
Seizures	□Yes □No □?	Constipation	□Yes □No □?
Psychiatric	□Yes □No □?	Genitourinary	
Ears, Nose, Mouth, Throat		UTI	□Yes □No □?
Allergy/hay fever	□Yes □No □?	Bones/Joints/Muscles	
Sinus Congestion	□Yes □No □?	Rheumatoid Arthritis	□Yes □No □?
Runny Nose	□Yes □No □?	Muscle Pain	□Yes □No □?
Post-nasal Drip	□Yes □No □?	Joint Pain	□Yes □No □?
Chronic Cough	□Yes □No □?	Lymphatic/Hematologic	
Respiratory		Anemia	□Yes □No □?
Asthma	□Yes □No □?	Endocrine	
Chronic Bronchitis	□Yes □No □?	Thyroid/other glands	□Yes □No □?

If you answered yes to any of the above, or have a condition not listed, please explain: _____

_____

_____

_____

_____

If you have had any surgeries, please list them here with approximate dates included: _____

_____

_____

_____

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DO I NEED A TEST FOR PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, and kidneys become narrowed or clogged. It affects over 12 million Americans, most over the age of 50. It may result in leg discomfort and fatigue with walking, poor healing of leg sores/ulcers, difficulty controlling blood pressure, stroke, and ultimately amputation. People with PAD are at significantly increased risk for stroke and heart attack. Age is not necessarily a factor. Young people can be affected too. **Many people with PAD never experience symptoms of any kind, which is why it is so important to identify those that are at risk. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.**

Patient Name: _____ Date: _____

Please circle yes or no for the following questions:

History:			**Test for PAD**
Do you have diabetes?	Yes	No	☐
Do you have high blood pressure?	Yes	No	☐
Do you have high cholesterol?	Yes	No	☐
Are you a current or past smoker?	Yes	No	☐
Do you have a history of coronary artery disease? (heart attack, stent, angioplasty)	Yes	No	☐
Do you have a history of peripheral vascular	Yes	No	☐
Symptoms:			
Do you have foot, calf, buttock, hip or thigh discomfort (aching fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
Do you experience pain at rest in your lower leg(s) or feet?	Yes	No	☐
Do you experience calf, foot or toe cramps/pain that disturbs your sleep?	Yes	No	☐
Are your toes or feet pale, discolored or bluish?	Yes	No	☐
Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
Has your doctor ever told you that you have diminished or absent foot pulses?	Yes	No	☐
Do you have pain or cramping in the leg muscles at night or when legs are elevated?	Yes	No	☐
Are you unable to walk as far as you once could?	Yes	No	☐

Patient Signature: _____

Physician Signature: _____ Date: _____

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NOTIFICATION OF PRIVACY PRACTICES:

By signing in the following space provided I hereby acknowledge that I have been informed of the privacy practices policy of Dr. Melchior P. Vallone and The Achilles Podiatry Center. A paper copy of the privacy practices policy was offered to me, and is available on our website. I have indicated below whether I accepted a copy of the policy or refused at this time. I understand that I can request a copy of this policy at any time.

- ❑ Yes, I accepted a copy of the privacy policy
- ❑ No, I refused a copy of the privacy policy at this time

Patient Name: _____

Signature of Patient or
Patient's Authorized Representative: _____

Relationship,
If other than Patient: _____

Today's Date: _____

PLEASE IDENTIFY A PERSON OR PERSONS THAT WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO (such as spouse, children, friend or caregiver):

_____

_____

Signature of Patient or
Patient's Authorized Representative: _____

Relationship,
If other than Patient: _____

Today's Date: _____

RECORD OF DISCLOSURES (other than for treatment, payment and healthcare operations):

DATE	DISCLOSED TO
_____	_____
_____	_____
_____	_____
_____	_____