Bitte lesen und unterzeichnen

Practice: LOMBARDI AND SILVER, LLP

**Name:**
**Race:**
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)
**Ethnicity:**
**Preferred Language:** English
**Pharmacy Name:**
**Pharmacy Address:**
**Primary Care Physician:**
**Address:**
**Referring Physician:**
**Phone:**
**City, State, Zip:**
**Date Last Seen:**

### Privacy Information Preferences
- Do you want to be exempt from public reporting?  Yes  No
- Can we send mail to the address on file?  Yes  No
- Can we call the phone number on file?  Yes  No
- Can we leave voicemail on machine?  Yes  No
- Will you allow us to send internet based (e-mail) delivery of reminders and newsletters?  Yes  No
- If yes, please provide your e-mail address:
- Who can we leave messages with?  Wife  Husband  Daughter  Son  Other: Name(s):

### Smoking Status
- Current Every Day Smoker  Never Smoker
- Current Some Day Smoker  I decline to answer
- Former Smoker

### Vital Signs
- Blood Pressure: _____ / _____
- Height: _____ Weight: _____

### Current Medications
- No Known Medications  I take the following medications:

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### Allergies
- No Known Allergies  No Known Drug Allergies

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**PLEASE READ AND SIGN:** The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor’s office to retrieve my medication history.

Patient Signature: ___________________________ Date: ___________________________

Rev 12/29/2011
### History and Physical

| Medical History: | □ Alcoholism | □ Blood disorders | □ Circulation problems | □ Musculoskeletal | □ Breathing issues |
| □ Liver | □ Sleep apnea | □ Gout | □ Allergies | □ Heart disease | □ Asthma |
| □ Heart murmur | □ Stomach/bowel | □ Depression | □ Anxiety disorder | □ Mental illness | □ Kidney disease |
| □ Blood clot | □ High cholesterol | | □ High blood pressure | □ Cancer | □ Hepatitis |
| □ Neuropathy (specify) | □ Thyroid disease (specify) | | | □ Diabetes (type 1, type 2) | |
| □ Arthritis (specify) | □ Other (specify) | | | □ HIV | □ CVA |

**Are you pregnant?** □ Yes □ No  **Are you nursing?** □ Yes □ No

### Surgical History

- □ None
- □ Appendectomy
- □ C-Section
- □ Angioplasty
- □ Bypass
- □ Cataracts
- □ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? □ Yes □ No

If yes, please describe: ____________________________

Do you have any artificial joints? □ Yes (where? ____________) □ No

Do you have an artificial heart valve? □ Yes □ No

### Social History

Do you smoke? □ Yes □ No  If yes how many packs per day? □ 1 □ 2 □ 3 □ 4 □ 5 For how long?

Do you drink alcohol? □ Yes, everyday (5-7 days/week) □ Yes, occasionally/socially □ No/Rarely

Substance abuse: □ Yes, I have a current substance abuse problem. Please specify: ____________________________

□ Yes, I had a past substance abuse problem. Please specify: ____________________________

□ No, I have never had a substance abuse problem

What is your occupation? ____________________________  Does it involve mostly □ standing or □ sitting

Do you exercise regularly? □ No, I do not exercise regularly □ Yes, I do the following ‘regular’ exercise: ____________________________

### Family History

□ Alzheimer's ____________________________  □ Depression ____________________________

□ Arthritis ____________________________  □ Diabetes ____________________________

□ Bleeding disorders ____________________________  □ Emphysema ____________________________

□ Blood clot ____________________________  □ Heart disease ____________________________

□ Cancer ____________________________  □ High Blood Pressure ____________________________

□ Cataracts ____________________________  □ Neurological ____________________________

□ Circulation problems ____________________________  □ Strokes ____________________________

□ Other (specify): ____________________________

### Review of Systems

(Please check the box if you currently have any of these symptoms or check “NONE”)

- □ Leg pain when walking
- □ Fever
- □ Chest pain/pressure
- □ Leg swelling
- □ Cold hands/feet

- □ Leg pain when standing
- □ Palpitations
- □ Vascular disease
- □ Valve problems
- □ NONE

- □ Blood in urine
- □ Hesitancy
- □ Incontinence
- □ Increased urgency
- □ Kidney stones
- □ NONE

- □ Increased frequency
- □ Excessive urination
- □ Kidney disease
- □ Constipation
- □ Increase appetite
- □ NONE

- □ Abdominal pain
- □ Trouble swallowing
- □ Decrease appetite
- □ Ulcers
- □ Constipation
- □ NONE

- □ Diarrhea
- □ Blood in stool
- □ Vomiting
- □ Constipation
- □ Increase appetite
- □ NONE

- □ Heartburn
- □ Nausea
- □ Indigestion
- □ Nausea
- □ Indigestion
- □ NONE

- □ Anemia
- □ Blood thinners
- □ Clotting disorders
- □ None
- □ None
- □ None

- □ Lower leg ulcers
- □ Sickle cell disease
- □ Anemia
- □ Blood thinners
- □ Clotting disorders
- □ NONE

- □ Tingling
- □ Weakness
- □ Seizures
- □ Numbness
- □ Headaches
- □ NONE

- □ Tremors
- □ Paralysis
- □ Headaches
- □ Headaches
- □ Headaches
- □ NONE

- □ Back pain
- □ Joint swelling
- □ Muscle weakness
- □ Muscle pain
- □ Neck pain
- □ NONE

- □ Sciatica
- □ Joint stiffness
- □ Joint pain
- □ Joint instability
- □ Arthritis
- □ NONE

- □ Respiratory
- □ Shortness of breath
- □ Emphysema
- □ COPD
- □ Coughing
- □ Snoring
- □ NONE

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**PLEASE READ AND SIGN**

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Patient Signature: ____________________________  Date: ____________________________

Rev 12/29/2011