ROBERT W. TINSLEY, D.P.M., P.A.
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons

INTERVAL MEDICAL UPDATE QUESTIONNAIRE

NAME:_____ **DOB:** _____/_____/_____ **AGE:**_____

ADDRESS:_____ **CITY:** _____**STATE:**_____**ZIP:**_____

TEL #:_____-_____-_____ **CELL# :**_____-_____-_____(we will text appointment reminder to you)

E-MAIL:_____(we will e-mail appointment reminder to you)

EMERGENCY CONTACT NAME:_____**RELATIONSHIP**_____ **PHONE #:**_____ -_____ -_____

SPOUSE NAME: _____ _____ **DOB:** _____/_____/_____ **NAME OF INSURANCE: PRIMARY** _____

SECONDARY_____ **REASON YOU ARE HERE TODAY**: _____

PHARMACY NAME AND NUMBER: _____

PRIMARY CARE PHYSICIAN NAME: _____ **ENDOCRINOLOGIST/CARDIOLOGIST NAME:** _____

CURRENT MEDICAL ILLNESS:
Please list any new medical problems which you have.

1._____

2._____

3._____

4._____

MEDICATIONS: (include dosage and frequency)
Please list all medication including eye drops, vitamins and over-the-counter preparations. **OR PROVIDE A LIST**

1. _____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

ALLERGIES:
Please list any new allergies and reactions.

1._____

2._____

SURGICAL HISTORY SINCE LAST UPDATE:
Please list any surgeries you have had **since your last update.** Please include the date of the procedure.

1._____

2._____

3._____

FAMILY ILLNESS HISTORY SINCE LAST UPDATE:
Please list any new medical problems any of your immediate family have developed **since your last update.**

1. _____

2. _____

3. _____

SOCIAL HISTORY:

ARE YOU A FORMER SMOKER? NO_____ YES_____ QUIT DATE: _____
DO YOU CURRENTLY SMOKE? NO_____ YES_____ # PACK A DAY_____
DO YOU DRINK ALCOHOLIC BEVERAGES? NO_____ YES_____ #/DAY_____ (PLEASE CHECK) BEER____WINE_____LIQUOR_____
DO YOU OR HAVE YOU EVER USED RECREATIONAL DRUGS? NO_____ YES_____ PREVIOUSLY_____

PATIENT SIGNATURE:_____**TODAYS DATE:**_____/_____/_____

ROBERT W. TINSLEY, D.P.M.

REVIEW OF SYSTEMS: Please check the appropriate response box for any symptoms you may be currently experiencing.

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

SYMPTOM	YES	NO
CONSTITUTIONAL		
Chills		
Fatigue		
Fever		
Night Sweats		
Weight Gain		
Weight Loss		
RESPIRATORY		
Coughing up blood		
Persistent cough		
Shortness of breath		
Sleep Apnea		
Wheezing		
CARDIAC		
Angina		
Chest pain or discomfort		
Fainting		
Leg or feet swelling		
Racing or skipping heartbeats		
Wake at night short of breath		

SYMPTOM	YES	NO
GASTROINTESTINAL		
Bloody stool		
Bowel changes		
Heartburn		
Indigestion		
Tarry stool		
Vomiting		
MUSCULOSKELETAL		
Back pain		
Back stiffness		
Joint pain		
Joint stiffness		
Joint swelling		
Sciatica		
NEUROLOGIC		
Change in thinking		
Double vision		
Headache		
History of stroke		
Numbness/tingling/burning of extremities		
Seizures		
Vertigo/Room spinning		
Weakness		

PATIENT SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

In addition to the allowable disclosures described in The Provider Notice of Practices, I hereby authorize disclosure of my protected health care information to the persons indicated below.

_____ ( ) YES ( )NO
Spouse

_____ ( ) YES ( )NO
Other/Name & Relation

_____ ( ) YES ( )NO
Other/Name & Relation

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature