**Kara L. Gordon, D.P.M., M.B.A.**

**Douglas RHC**

100 E. 5th St. Douglas, AZ 85607

Phone: 520-805-6800

Fax: 520-364-8541

**Palominas RHC**

10524 E. Hwy 92, Palominas, AZ 85615

Phone: 520-366-0300

Fax: 520-366-9841

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May our office staff leave a message on your voicemail regarding appointments, billing questions, or prescription information? ☐ YES ☐ NO

Please list the names of any individuals that our office staff has permission , which is given by you, to speak with:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party PRINT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION CONSENT**

Our system can pull your prescribed medications directly from your pharmacy when available. Please sign below giving us your consent.

Patient Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shoe Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** ☐No Know Allergies ☐Penicillin ☐Morphine ☐Tape\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:** Please indicate if you currently have or have ever had any of the following.

|  |  |  |  |
| --- | --- | --- | --- |
| ☐None  | ☐Diabetes Type 1 | ☐Hepatitis or Jaundice | ☐Osteoarthritis |
| ☐Acid Reflux | ☐Diabetes Type 2 | ☐High Blood Pressure | ☐Vascular Disease |
| ☐Anemia | ☐Diabetes Neuropathy | ☐High Cholesterol | ☐Respiratory Problems |
| ☐Arthritis | ☐Dialysis | ☐HIV | ☐Rheumatoid Arthritis |
| ☐Asthma | ☐Epilepsy | ☐Kidney Disease | ☐Sickle Cell Disease |
| ☐Back Problems | ☐Fibromyalgia | ☐Kidney Stones | ☐Stroke |
| ☐Bleeding Disorder | ☐Gastric Ulcers | ☐Leg or Foot Ulcer/Sores | ☐Thyroid Disease |
| ☐Bone/Muscle Problem | ☐Gout | ☐Liver Disease | ☐Tuberculosis |
| ☐Cancer | ☐Head/Brain Injury | ☐Low Blood Pressure | ☐Varicose Veins |
| ☐Circulatory Problems | ☐Hearing Impaired | ☐Lupus | ☐Venereal Disease |
| ☐COPD | ☐Hemophilia | ☐Mental Health Problems | ☐Other: |
| ☐Currently Pregnant | ☐Heart Disease  | ☐Multiple Sclerosis |  |

**Past Surgeries:** ☐ None ☐ See Attached **Social History**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tabacco use: ☐Never ☐Past ☐Current-How much?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol Use: ☐Never ☐Past ☐Current-How much?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Illicit Drug Use: ☐Never ☐Past ☐Current-What?

**Family History**(If any family history, please not WHO nest to the condition.)

|  |  |  |
| --- | --- | --- |
| ☐ No Medical Problems | Diabetes | Leg or Foot Ulcers |
| ☐ Don’t Know | Gout | Liver Problems |
| Arthritis | Heart Disease | Respiratory Problems |
| Cancer | High Blood Pressure | Stroke |
| Circulatory Problem | Kidney Problem | Sickle Cell Disease  |

**Current Medications:** ☐None ☐See Attached

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Symptoms:** Please check items that **currently** apply to you.

|  |  |  |  |
| --- | --- | --- | --- |
| **General** ☐Fatigue☐Fever☐Night sweats☐Recent weight changes☐Other | **Cardiovascular**☐Chest Pains☐Circulatory Problems☐Heart attack☐Heart Problems☐Rapid Heartbeat☐Fatigue/Weakness☐Varicose Veins☐Other | **Ear,Nose,and Throat**☐Breathing Difficulty☐Ear Discharge☐Ear pain☐Hearing issues☐Hoarseness☐Nose Bleeding☐Nose discharge☐Nose Obstruction☐Nose Pain☐Sore Gums☐Sore Throat☐Other | **Respiratory**☐Coughing Blood☐Coughing Phlegm☐Difficulty Breathing☐Lung Problems☐Persistent Cough☐Shortness of Breath☐Wheezing☐Other |
| **Eyes**☐Eye Strain☐Eye Pain☐Vision Problems☐Other | **Gastrointestinal**☐Abdominal pain☐Belching☐Black/Bloody Stool☐Difficulty swallowing☐Gas/Bloated☐Hemorrhoids☐Indigestion☐Poor Appetite☐Vomiting☐Other | **Genitourinary**☐Bladder Trouble☐Blood in Urine☐Difficulty Urinating ☐Discolored Urine☐Excessive Urination☐Frequency of Urination☐Painful Urination☐Prostate Problems☐Other | **Skin**☐Abrasions☐Bruises☐Rash☐Hives☐Sores/Ulcers☐Itching☐Other |
| **Endocrine**☐Excessive Thirst☐Excessive Hunger | **Musculoskeletal**☐Frequent Sprains☐Joint Pain☐Muscle Pain☐Stiffness | **Hematologic**☐Take Aspirin☐Take Coumadin | **Psychiatric**☐Depression☐Anxiety  |

What is your Foot Complaint?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a foot or ankle surgery? ☐ No ☐ Yes: What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was your foot doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Place “X” where you are having pain:

