



*Kara L. Montes, D.P.M.*

10524 E Highway 92, Palominas, Az 85615  
100 E 5<sup>th</sup> Street, Douglas, Az 85607

(520) 459-3339

CONTACT CONSENT

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

Home Phone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

May our office staff leave any messages on your home answering machine regarding appointments, billing questions or prescription information?

Yes \_\_\_\_\_ No \_\_\_\_\_

May our staff leave a message at your work place?

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 \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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

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

MEDICATION CONSENT

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

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

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



# Kara L. Montes D.P.M.

Patient Personal/Medical History

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

How did you hear about us? Please let us know:  Dr. \_\_\_\_\_  Newspaper  Dex Phone Book  
 Internet  Friend/Relative  While you Wait Ad  The Local Pages book  SVRHC Guide  Buena Banner  
 SV Chamber  Radio Ad  Other: \_\_\_\_\_

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

**Allergies:** None Known

Penicillin  Morphine  Tape \_\_\_\_\_  Sulfa Drugs  Antibiotics \_\_\_\_\_  Any foods \_\_\_\_\_  Aspirin  
 Codeine  Other \_\_\_\_\_

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

<input type="checkbox"/> None	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Hepatitis or <input type="checkbox"/> Jaundice	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes Neuropathy	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dialysis	<input type="checkbox"/> HIV	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Skin Disease: _____
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gastric Ulcers	<input type="checkbox"/> Leg or Foot Ulcer/Sore	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bone/Muscle Problem _____	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer (type): _____	<input type="checkbox"/> Head/Brain Injury	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Lupus	<input type="checkbox"/> Varicose Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/>

**Past surgeries:**  None  See attached

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

**Social History** Occupation: \_\_\_\_\_

Tobacco Use:  Never  Past  Current-How much? \_\_\_\_\_

Alcohol Use:  No  Yes If yes  Occasional  Daily

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

**Family History:** (if any family history, please note **who** next to condition)

<input type="checkbox"/> No Medical Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leg or Foot Ulcers
<input type="checkbox"/> Don't know	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Sickle Cell Disease

**Current medications:**  None  See attached

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

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Review of systems:** Please check items in each category that **PRESENTLY** apply to you.

<u>General</u> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Recent Weight change <input type="checkbox"/> Other	<u>Eyes</u> <input type="checkbox"/> Eye strain <input type="checkbox"/> Eye pain <input type="checkbox"/> Vision problem <input type="checkbox"/> Other	<u>Musculoskeletal</u> <input type="checkbox"/> Frequent sprains <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Other	<u>Hematologic</u> <input type="checkbox"/> Take aspirin <input type="checkbox"/> Take Coumadin <input type="checkbox"/> Other
<u>Ears, Nose and Throat</u> <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Nose discharge/obstruction <input type="checkbox"/> Nose pain <input type="checkbox"/> Sore gums <input type="checkbox"/> Sore throat <input type="checkbox"/> Other	<u>Genitourinary</u> <input type="checkbox"/> Bladder trouble <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Discolored urine <input type="checkbox"/> Excessive urination <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Prostate problems <input type="checkbox"/> Other	<u>Cardiovascular</u> <input type="checkbox"/> Chest pain <input type="checkbox"/> Circulatory problems <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart problems <input type="checkbox"/> Pain over heart <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Tiredness <input type="checkbox"/> Varicose veins <input type="checkbox"/> Weakness <input type="checkbox"/> Other	<u>Neurological</u> <input type="checkbox"/> Confusion <input type="checkbox"/> Convulsions <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of feeling <input type="checkbox"/> Muscle jerking <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling in legs/feet <input type="checkbox"/> Other
<u>Gastrointestinal</u> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Belching <input type="checkbox"/> Black stool <input type="checkbox"/> Bloody stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Poor appetite <input type="checkbox"/> Stomach trouble <input type="checkbox"/> Vomiting <input type="checkbox"/> Other	<u>Respiratory</u> <input type="checkbox"/> Coughing blood <input type="checkbox"/> Coughing phlem <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Lung problems <input type="checkbox"/> Persistent cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other	<u>Skin</u> <input type="checkbox"/> Abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Discolorations <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Moles <input type="checkbox"/> Poor wound healing <input type="checkbox"/> Skin rash <input type="checkbox"/> Sores <input type="checkbox"/> Other	

What is your main foot complaint? \_\_\_\_\_

Have you ever had a foot/ankle surgery?  YES  NO

If yes, what was the surgery? \_\_\_\_\_

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

**Responsible party signature:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_

Relationship to patient:  SELF  POA  PARENT  other \_\_\_\_\_

Name: \_\_\_\_\_



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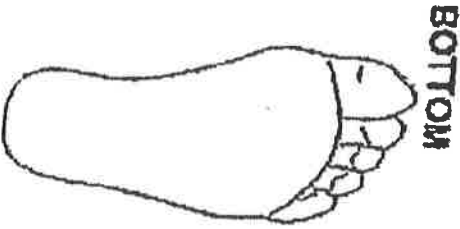
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PATIENT NAME: \_\_\_\_\_

Place an "X" where you have pain:

SITE:  Right  Left



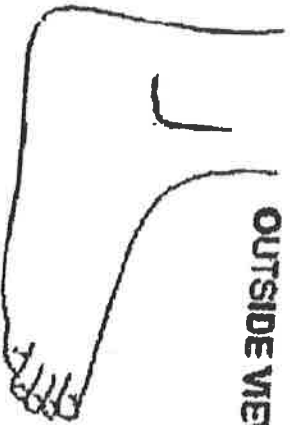
**BOTTOM**



**TOP**



**INSIDE VIEW**



**OUTSIDE VIEW**