

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ (for insurance)

NAME OF INSURANCE: PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

REASON YOU ARE HERE TODAY: \_\_\_\_\_

PHARMACY NAME AND NUMBER: \_\_\_\_\_

**CURRENT MEDICAL ILLNESS SINCE LAST UPDATE:**

Please list any new medical problems which you have.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**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. \_\_\_\_\_

**NEW ALLERGIES SINCE LAST UPDATE:**

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

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

<b>SYMPTOM</b>	<b>YES</b>	<b>NO</b>
<b>GASTROINTESTINAL</b>		
Bloody stool		
Bowel changes		
Heartburn		
Indigestion		
Tarry stool		
Vomiting		
<b>MUSCULOSKELETAL</b>		
Back pain		
Back stiffness		
Joint pain		
Joint stiffness		
Joint swelling		
Sciatica		
<b>NEUROLOGIC</b>		
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