Robert W. Tinsley, D.P.M., P.A.

Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons
Fellow of the College of Certified Wound Specialists

INTERVAL MEDICAL UPDATE QUESTIONNAIRE

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

ADDRESS:_____ CITY: _____STATE:_____ZIP:_____

TEL #:_____-_____-_____ CELL#:_____-_____-_____ E-MAIL:_____

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

SPOUSE NAME:_____ DOB:_____/_____/_____ SS#:_____-_____-_____

NAME OF INSURANCE: PRIMARY_____ SECONDARY_____

REASON YOU ARE HERE TODAY:_____

CURRENT MEDICAL ILLNESESS:
Please list any medical problems which you presently have.

1._____
2._____
3._____
4._____

ALLERGIES:
Please list any new allergies and reactions.

1._____
2._____

MEDICATIONS: (include dosages)
Please list all medication including eye drops, vitamins and over-the-counter preparations. Also include medications you are supposed to be taking, but are not. (Indicate with a star*)

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____
11._____ 12._____
(continue on back if necessary)

SURGICAL HISTORY:
Please list any operations you have had since your last evaluation and the date of the procedure.

1._____
2._____
3._____

FAMILY ILLNESS HISTORY:
Please list any new medical problems any of your immediate family have developed.

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_____
DO YOU OR HAVE YOU EVER USED RECREATIONAL DRUGS? NO_____ YES_____ PREVIOUSLY_____

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

7341 Office Park Place, Unit 103
Viera, Florida 32940
(321) 253-4973 • Fax (321) 253-4913

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		
NEUROLIGIC		
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