CAROLINA MUSCULOSKELETAL INSTITUTE, PA

PODIATRY DIVISION – DISEASES AND SURGERY OF THE FOOT
721 RICHLAND AVENUE WEST, SUITE 100
AIKEN, SOUTH CAROLINA 29801
803.644.4264

MACKIE J.WALKER, JR.,DPM **ANGELA H. MOLNAR, DPM**

DATE _____/_____/_____

NAME _____ BIRTH DATE ____/____/____ AGE _____ YRS

ADDRESS _____ CITY_____ ZIP _____

SSN_____/_____/_____ HOME PHONE _____CELL PHONE _____

MARITAL STATUS_____ REFERRED BY _____

PRIMARY PHYSICIAL (FAMILY DOCTOR)_____ DATE OF LAST VISIT_____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR) _____SSN _____

EMPLOYER _____LENGTH OF EMPLOYMENT_____

EMPLOYER ADDRESS _____TELEPHONE _____

SPOUSE'S NAME _____SPOUSE'S BIRTH DATE _____/_____/_____

SPOUSE'S SSN _____/_____/_____ SPOUSE'S EMPLOYER _____

IN CASE OF EMERGENCY, NOTIFY _____PHONE _____

IF YOUR PROBLEM IS THE RESULT OF AN INJURY AT WORK, DO YOU HAVE WORKER'S COMPENSATION COVERAGE? □ YES □ NO

THANK YOU FOR COMPLETING THE ABOVE FORM.

PLEASE READ THE STATEMENTS BELOW, SIGN YOUR NAME, AND DATE.
WE APPRECIATE YOU CHOOSING US TO PROVIDE YOUR MEDICAL CARE!

CERTIFICATION: I DO HEREBY STATE THE INFORMATION PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PAYMENT GUARANTEE: I HEREBY AGREE TO PAY THE ESTABLISHED RATES OF THIS OFFICE FOR ALL SERVICES RENDERED TO ME OR MY DEPENDENTS WHILE I AM/THEY ARE UNDER THE CARE OF CAROLINA MUSCULOSKELETAL INSTITUTE, PA.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I DO HEREBY AUTHORIZE CAROLINA MUSCULOSKELETAL INSTITUTE, PA TO PERMIT ANY INSURER PROVIDING ME OR MY DEPENDENTS UNDER THEIR CARE TO INSPECT THE MEDICAL RECORD IN CONNECTION WITH ANY CHARGES ARISING FROM MY TREATMENT IN THIS OFFICE. I FURTHER AUTHORIZE ANY SUCH INSURER TO PAY DIRECTLY TO CAROLINA MUSCULOSKELETAL INSTITUTE, PA ANY PAYMENTS FOR CHARGES ARISING FROM SERVICES TO ME.

SIGNATURE:_____DATE:_____WITNESS:_____

MEDICAL HISTORY INFORMATION SHEET DATE _____/_____/_____

MACKIE J. WALKER, JR., DPM ANGELA H. MOLNAR, DPM

IMPORTANT! PLEASE READ THE QUESTIONS BELOW CAREFULLY. PLEASE ANSWER ALL QUESTIONS SO THAT THE DOCTOR MAY EVALUATE YOUR PROBLEM IN THE MOST THOROUGH MANNER AND PROVIDE YOU WITH THE BEST POSSIBLE CARE.

NAME _____ BIRTH DATE_____/_____/_____ AGE_____YRS

SEX _____ RACE_____ HEIGHT_____FT_____IN WEIGHT _____LBS SHOE SIZE _____ LENGTH_____WIDTH

WOMEN, ARE YOU PREGNANT? □ YES _____ MONTHS □NO □MAYBE

NATURE OF COMPLAINT/PROBLEM

RIGHT FOOT _____ ONSET_____ DURATION_____

LEFT FOOT _____ ONSET_____ DURATION_____

ASSOCIATED PROBLEMS _____

_____

PAST PODIATRIC MEDICAL HISTORY

FORMER PODIATRIST _____DATE OF LAST VISIT _____

ALLERGIES (PLEASE CHECK IF YOU ARE ALLERGIC TO) □ NOVACAINE □ PENICILLIN □ IODINE □ ADHESIVE TAPE □SULFA DRUGS

□ OTHER MEDICATIONS (PLEASE LIST) _____

MEDICATIONS (NAME AND DOSAGE) _____

_____

HAVE YOU OR YOUR FAMILY EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS/PROBLEMS?

HEART PROBLEMS □YOU □FAMILY
LIVER PROBLEMS □YOU □FAMILY
ARTHRITIS □YOU □FAMILY
CANCER □YOU □FAMILY
EPILEPSY □YOU □FAMILY
KIDNEY PROBLEMS □YOU □FAMILY
STOMACH PROBLEMS □YOU □FAMILY
BRUISE EASILY □YOU □FAMILY
ASTHMA □YOU □FAMILY
GOUT □YOU □FAMILY
KELOID SCARS □YOU □FAMILY
HIGH BLOOD PRESSURE □YOU □FAMILY
SLOW HEALING TIME □YOU □FAMILY
LUNG PROBLEMS □YOU □FAMILY
RHEUMATIC FEVER □YOU □FAMILY
AIDS/HEPETITIS/OTHER RELATED DISEASES □YOU □FAMILY **OTHER** _____

ARE YOU **DIABETIC**? □NO □ YES IF YES, DATE OF LAST BLOOD SUGAR _____RESULTS_____

OPERATIONS/ILLNESSES/INJURIES (DATES) _____

_____

HAVE YOU EVER RECEIVED GENERAL ANESTHESIA? □NO □ YES ANY PROBLEMS? _____

DO YOU SMOKE? □NO □ YES PACKS/DAY _____ DO YOU DRINK? □NO □ YES AMOUNT/DAY _____

DO YOU FREQUENTLY HAVE LEG CRAMPS? □NO □ YES IF SO, WHEN? _____

GENERAL AND INFORMED CONSENT FOR TREATMENT: I HEREBY REQUEST AND AUTHORIZE CAROLINA MUSCULOSKELETAL INSTITUTE, PA OR ITS DESIGNEE TO ADMINISTER TREATMENT AND TO PERFORM SUCH GENERAL PROCEDURES AS MAY BE NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY FOOT CONDITION. I FURTHER CERTIFY THAT THE INFORMATION PROVIDED IN THE MEDICAL HISTORY ABOVE IS TRUE AND ACCURATE.

SIGNATURE: _____ DATE: _____ WITNESS: _____

PODIATRIC EXAMINATION TO BE COMPLETED BY THE DOCTOR DATE _____/_____/_____

CAROLINA MUSCULOSKELETAL INSTITUTE, PA

MACKIE J. WALKER, JR., D.P.M. ANGELA H. MOLNAR, D.P.M.

PATIENT'S NAME _____ DATE OF BIRTH _____/_____/_____

VITAL SIGNS: BY _____ PULSE _____/MIN; TEMP_____°F; RESP _____/MIN; B.P. _____/_____(R) (L)

INTEGUMENT

	TEMP.	MOISTURE	TURGOR	HAIR DIST.	COLOR
RIGHT					
LEFT					
	HYPERKERATOSES (Location and severity)				
RIGHT					
LEFT					

OTHER FINDINGS:_____

CONDITION OF TOE NAILS

□ Hypertrophic nail plate(s):_____
□ Discoloration of nail plate(s):_____
□ Subungual debris of:_____
□ Onycholysis: _____
□ Onychocryptosis: _____
□ Paronychia: _____
□ Other _____

VASCULAR

(OUT OF FOUR)

	DORSALIS PEDIS A	POSTERIOR TIBIAL A	POPLITEAL A	CFT (sec)	VARICOSITIES	EDEMA
RIGHT						
LEFT						

OTHER FINDINGS: _____

NEUROLOGICAL

(OUT OF FIVE)

	MOTOR REFLEXES		SENSORUM					PATHOLOGICAL –(+)		
	PATELLAR	ACHILLES	SHARP/DULL	LIGHT TOUCH	MONOFILAMENT	VIBRATORY	ABADIES	BABINSKI	CLONUS	RHOMBERG
RIGHT										
LEFT										

□ SEE WEST TEST OTHER FINDINGS: _____

MUSCULO-SKELETAL

(OUT OF FIVE)

	MUSCLE STRENGTH				RANGE OF MOTION OF JOINTS			
	INVERSION	EVERSION	DORISIFLEXION	PLANTARFLEXION	ANKLE	SUBTALAR	MIDTARSAL	FIRST MPJ
RIGHT								
LEFT								

	FOOT TYPE-STANDING									
	RECTUS	MILD PLANUS	MOD PLANUS	SEV PLANUS	MILD CAVUS	MOD CAVUS	SEV CAVUS	FLX	RGD	RCSP°
RIGHT										
LEFT										

GAIT ANALYSIS: _____
LIMB LENGTH: _____ POSTURE: _____

DEFORMITIES

	HAV	CD2	CD3	CD4	CD5	PM1	PM2	PM3	PM4	PM5	T.B.	OTHER
RIGHT												
LEFT												

OTHER FINDINGS:_____

ADDITIONAL NOTES/FINDINGS: _____

_____

_____

(Continued in Progress Notes) _____ DPM Date ____/____/____

GENERAL PROGRESS NOTES

PATIENT'S NAME _____ DOB _____/_____/_____ TEL. _____

ALLERGIES: _____ CHRONIC DISEASES: _____

INITIAL PROGRESS NOTES				
SEE HISTORY AND PHYSICAL				
X-RAY STUDIES ORDERED (if ind.) TO:				
□ AP □ LAT □ OBL □ OTHER-		□ TOES-	□ FOOT-	□ ANKLE-
FINDINGS:				
OTHER STUDIES ORDERED (if any):				
IMPRESSIONS:	(1)		(2)	
	(3)		(4)	
	(5)		(6)	
RECOMMENDATIONS/ADVISE:	□ NATURE OF ABOVE CONDITIONS, ETIOLOGY, AND TREATMENT MODALITIES AVAILABLE FOR SAME:			
WRITTEN / ORAL INSTRUCTIONS / INFORMATION GIVEN RE:				
□ RE SHOE GEAR:		□ RE SELF CARE:		
OTHER:				
TREATMENT:	□ SEE PT PLAN	□ WHIRLPOOL _____ MINUTES	□ULTRASOUND	□IONTOPHORESIS
□ INJECTION (Dose/Site):				
□ DISPENSED				
□ Rx		DISP.	SIG.	
Rx		DISP.	SIG.	
Rx		DISP.	SIG.	
□ PARING OF LESIONS WITH SCAPEL				
□ MANUAL / MECHANICAL DEBRIDEMENT OF NAILS _____ FT.				
□ OTHER				

PTR _____ □ Days □Weeks □ Months _____ DPM Date ____/____/____