# SassiFeet, LLC
## Dr. MICHAEL DAVID SASSINE, DPM

Patient Name: _____ Date of Birth: ___/___/____

Name of Guardian (patients under 18): _____

Address: _____
Street Apt/PO Box City State Zip

Contact Number: (please check preferred contact number)
☐ Cell Phone: _____ ☐ Home Phone: _____ ☐ Work Phone: _____
Check here if we are able to leave a message on your preferred contact number: ☐

E-Mail Address: _____ Check here if you do not have an e-mail ☐

Gender: ☐ Male ☐ Female

Marital Status: ☐ S ☐ M ☐ W ☐ D

Race:
☐ White ☐ American Indian/Alaskan Native
☐ Asian ☐ Black or African American
☐ Native Hawaiian/other pacific island nation
☐ Prefer to not specify

Ethnicity:
☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Prefer to not specify

Emergency Contact: _____ Relation to patient: _____ Phone Number: _____

Primary Physician: _____
Name City State
Approximate date you were last seen by your primary doctor: ____/____/____

Preferred Pharmacy: _____
Name Street Name City

Name of Employer: _____ Occupation: _____
Address: _____
Street City State Zip
Phone Number: _____

Primary Health Insurance: _____
If you are not the primary insurance carrier please complete:
Name of Primary Policy Holder: _____
Address: _____
Street City State Zip
Date of Birth: ____/____/

**Authorization for Medical Treatment:** The undersigned hereby authorizes the practice of SassiFeet, LLC by Dr. Michael David Sassine, DPM to provide medical care which may include minor procedures and administer anesthetics as considered necessary and proper in the treatment as provided by law.

_____ _____
Signature of Patient or Guardian Date

DR. Michael David Sassine, DPM | 2100 E sample Rd. Suite 203 |Lighthouse Point, FL 33064
(P) 305-216-4556 email: Dr.sassifeet@gmail.com

# SassiFeet, LLC
## Dr. MICHAEL DAVID SASSINE, DPM

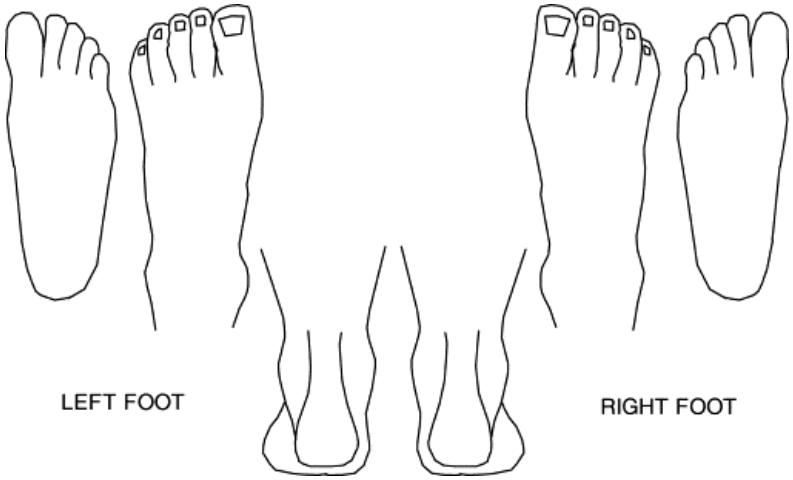
## New Patient Questionnaire

| Patient Name: | Date of Birth: / / | Age: |
|---|---|---|
| Shoe Size: | Weight: lbs. | Height: |

Primary Reason for Visit Today:

_____

Circle the affected area of your foot:




Describe the Symptoms:

☐ Pain ☐ Burning ☐ Aching
☐ Swelling ☐ Painful Toenail ☐ Thick Toenail
☐ Other (Please Explain):

Circle Level of Pain Below:

(Less Pain) 0 1 2 3 4 5 6 7 8 9 10 (More Pain)

How long have symptoms been present? _____ days/weeks/months/years (please circle one)

Was there an injury associated with the onset of your symptoms? ☐ No ☐ Yes

If yes, please provide description and date if possible:

_____

Is this a work related injury? ☐ No ☐ Yes

Have you tried to treat the condition? ☐ No ☐ Yes

If yes, please describe (e.g. Motrin, different shoes, inserts, etc.):

_____

What makes the condition worse? (e.g. prolonged standing, high heels, barefoot)

_____

Additional issues or concerns today:

_____

_____

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## Health History

**Allergies:** (Check the medications of substances you have an allergy to)

No known allergies: ☐

- Antibiotics: ☐ Penicillin ☐ Sulfa ☐ Cipro ☐ Keflex ☐ Erythomycin ☐ Other_____
- Pain Medications: ☐ Aspirin ☐ NSAIDS ☐ Codeine ☐ Morphine ☐ Vicodin ☐ Other_____
- Miscellaneous: ☐ Iodine ☐ Contract dye ☐ Adhesive Tape ☐ Latex ☐ Anesthetics (☐ Local/☐ General)
- Other: _____

**Medication List:** (List all medications, vitamins, and supplements)

_____

_____

_____

☐ Check here if attaching medication list

☐ Currently taking no medications

**Medical History:** (Check any medical conditions you currently have or have ever been treated for)

| | | |
|---|---|---|
| ☐ No known medical conditions | ☐ A-Fib | ☐ Alzheimer's/Dementia |
| ☐ Arthritis | ☐ Asthma | ☐ Bleeding Disorder: |
| ☐ Cancer (type): | ☐ Chronic Back Pain | ☐ Chronic Heartburn/Acid Reflux |
| ☐ COPD | ☐ Coronary Artery Disease | ☐ Depression |
| ☐ Deep Vein Thrombosis (DVT) | ☐ Dialysis | |
| ☐ Diabetes(year diagnosed)_____ | Under Control ☐ yes/ ☐ no | Last A1C (if known) _____ |
| ☐ Gout | ☐ Heart Attack | ☐ Heart Failure (CHF) |
| ☐ High Blood Pressure | ☐ High Cholesterol | ☐ HIV/AIDS |
| ☐ Liver Condition | ☐ Multiple Sclerosis | ☐ Pacemaker |
| ☐ Psoriasis | ☐ Reduced Function | ☐ Rheumatoid Arthritis |
| ☐ Kidney Transplant | ☐ Thyroid Condition | ☐ Stroke |

☐ Other: _____

**Family Medical History:** (Check all that apply)

| | | |
|---|---|---|
| ☐ Bleeding Disorder | ☐ Blood Clots | ☐ Diabetes |
| ☐ Gout | ☐ Heart Disease | ☐ Psoriasis |
| ☐ Rheumatoid Arthritis | ☐ Stroke | ☐ Thyroid Condition |
| ☐ Unknown | | |

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## Health History (continued)

**Surgical History**

Any history of adverse reaction to anesthesia? ☐ No ☐ Yes
If yes, please describe:
_____

Prior foot or ankle surgery? ☐ No ☐ Yes
If yes, please describe:
_____

_____

Any other prior surgeries? ☐ No ☐ Yes
If yes, please describe:
_____

_____

**Social History**

- Employment Status: ☐ Currently Employed ☐ Retired ☐ Unemployed ☐ Disability
- Activity Level: ☐ Active/Athletic ☐ Moderate ☐ Low/Sedentary
- Living Arrangements: ☐ Own Home/Apartment ☐ Live with Relatives ☐ Assisted Care Facility ☐ Live Alone ☐ Live with Spouse
- Tobacco Use: ☐ Never ☐ Current Smoker ☐ Former Smoker

If current or former smokers, how many packs per day/year (please circle one)?
Approximate *Start* Date _____
Approximate *Stop* Date (if applicable) _____

- Alcohol Use: ☐ No ☐ Yes

If yes, how many drinks per week? _____

- Recreational Drug Use: ☐ Marijuana ☐ Meth ☐ Cocaine ☐ Other: _____

**Female Patients Only**

Are you currently pregnant? ☐ No ☐ Yes
Are you currently nursing? ☐ No ☐ Yes

# SassiFeet, LLC
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## Health History (continued)

**Systems Review**
Within the past 60 days, have you had experience any of the following? (Check all that apply)

| | | |
|---|---|---|
| General | ☐ Nausea ☐ Fever | ☐ Unexplained weight loss/gain |
| Cardiac | ☐ Chest Pain<br>☐ Difficulty breathing when laying down | ☐ Prior Stroke<br>☐ Shortness of breath with activity |
| Peripheral Vascular | ☐ Fatigue in calf muscle with walking<br>☐ Toes turn blue, painful with cold weather<br>☐ Frequent or chronic swelling of legs<br>☐ Frequent pain in feet or legs at night<br>☐ Non-healing or delayed healing of wound on leg | ☐ Pain, swelling, or feeling of tightness in leg<br>☐ Prior blood clot of leg<br>☐ Varicose veins |
| Neurological | ☐ Dizziness, light headed, or fainting<br>☐ Difficulty with balance | ☐ Weakness or paralysis |
| Peripheral Neurological | ☐ Burning, tingling, or stinging of feet<br>☐ Weakness of one or both feet | ☐ Numbness of one or both feet |
| Gastrointestinal | ☐ Abdominal Pain<br>☐ Bloody Stool | ☐ Frequent Heartburn<br>☐ Unexplained change in bowel movements |
| Skin | ☐ Excessive Sweating of feet or hands<br>☐ Excessive odor of feet<br>☐ Chronic or recurrent skin rash | ☐ Suspicious skin lesion on foot/feet/leg(s)<br>☐ Black toenails |
| Musculoskeletal | ☐ Low back pain ☐ Hip Pain<br>☐ Joint stiffness or swelling | ☐ Knee pain<br>☐ Difficulty walking |
| Endocrine | ☐ Delayed healing of wounds<br>☐ Intolerance to cold or heat | ☐ Excessive thirst<br>☐ Frequent urination |
| Hematology/ Oncology | ☐ Anemia ☐ Bleed or bruise easily<br>☐ Swollen lymph nodes | ☐ Anticoagulant use |
| Respiratory | ☐ Require supplement oxygen<br>☐ Shortness of breath/difficulty breathing | ☐ Sleep apnea<br>☐ Snoring |
| Genitourinary | ☐ Burning or pain with urination<br>☐ Frequent urinary tract infections | ☐ Urinary incontinence<br>☐ Currently pregnant |
| Mental Health | ☐ Substance abuse/addiction<br>☐ Frequent episodes of memory loss/confusion | ☐ Anxiety<br>☐ Depression |
| Ear, Nose, Mouth, Throat | ☐ Difficultly hearing<br>☐ Difficulty swallowing | ☐ Frequent nose bleeds<br>☐ Bleeding gums |
| Eyes | ☐ Vision loss/blindness | ☐ Blurry or double vision |
| Check here if you have not experienced any of the above: ☐ | | |

Patient Signature _____ Date _____

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