PODIATRIC INFORMATION SHEET

NAME:_____TODAY'S DATE:_____

DATE OF BIRTH:_____

PRIMARY CARE PHYSICIAN'S NAME: _____

Has your address, telephone number, or insurance changed since your last visit here? **YES or NO**

ARE YOU DIABETIC? YES or NO

If yes: PHYSICIAN TREATING YOUR DIABETES: _____

(*This cannot be a Nurse Practitioner or Physician's Assistant)* DATE LAST SEEN:_____

MEDICARE DOES NOT COVER ROUTINE FOOT CARE.
MEDICARE COVERS TREATMENT OF MYCOTIC (Fungal) NAILS EVERY 60 DAYS WHEN:

1. You have a systemic disease (i.e., diabetes, atherosclerosis), and certain class findings are present. Please discuss with your doctor.
2. When you do not have a systemic disease but there is clinical evidence of mycosis present AND one of the following is present:
   a. Pain
   b. Secondary infection associated with the fungal nails
   c. Marked limitation of ambulation

In order to help us determine if your nail care is a covered service under Medicare guidelines, **please answer the following questions:**

1. Do you have conditions such as diabetes, poor circulation, or numbness in your feet currently being treated by your primary care physician? **YES or NO**

2. Are your toenails affecting your ability to walk? **YES or NO**

3. Are your toenails causing you pain or discomfort? **YES or NO**

4. Do you have pain or infection in your lower limb? **YES or NO**
   If Yes, please describe:

   _____

5. Do you have pain when wearing shoe gear, pain when walking, tenderness, redness, drainage, other? **YES or NO**
   If Yes, please describe:

   _____

Signature:_____ Date:_____

Podiatric Information Sheet

PQRS

Patient Name_____ Date_____

E-Mail Address_____

1. If you are diabetic, what was your last HBa1C _____

2. Have you had a Pneumonia vaccine? YES or NO

3. Have you had a influenza shot between October 1st and March 31st? YES or NO

4. Do you use tobacco products? YES or NO

5. Has your doctor prescribed medication to treat high blood pressure (hypertension)? YES or NO

6. Do you have an advanced care plan or surrogate decision maker? YES or NO

   If you have a surrogate decision maker, who is it? _____

7. Have your medications changed? YES or No If yes, please provide a list