OFMC
OCALA FAMILY
MEDICAL CENTER

**NAME:** _____ **DOB:** _____ **SHOE SIZE**_____

**PRIMARY COMPLAINT:** _____

**RIGHT FOOT (PLEASE CIRCLE IF IT APPLIES)**

| | | | | |
|---|---|---|---|---|
| WHOLE FOOT | BALL OF FOOT | TOP OF FOOT | ARCH | HEEL |
| GREAT TOE | SECOND TOE | THIRD TOE | FOURTH TOE | LESSER TOE |
| ANKLE | LEG | NAIL FUNGUS | INGROWN | |

**LEFT FOOT (PLEASE CIRCLE IF IT APPLIES)**

| | | | | |
|---|---|---|---|---|
| WHOLE FOOT | BALL OF FOOT | TOP OF FOOT | ARCH | HEEL |
| GREAT TOE | SECOND TOE | THIRD TOE | FOURTH TOE | LESSER TOE |
| ANKLE | LEG | NAIL FUNGUS | INGROWN | |

**NATURE OF THE PAIN**

SHARP DULL ACHING BURNING RADIATING STABBING ITCHING OTHER_____

**Pain Scale:** 1-10 (1=LOW/10=HIGH) 1 2 3 4 5 6 7 8 9 10

**IS YOUR PROBLEM:** OCCASIONAL FREQUENT INTERMITTENT CONSTANT

**SWELLING**? NONE MILD MODERATE SEVERE

**HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM? WHEN? TREATMENT? DR'S NAME**

_____

**WHAT HOME TREATMENTS HAVE YOU ATTEMPTED, IF ANY?**

ORAL/TOPICAL MEDICATIONS ICE NEW SHOES INSERTS REDUCED ACTIVITY

**WHEN DID THE PROBLEM START?** DAYS_____ WEEKS____ MONTHS_____ YEARS_____

**IS THE PROBLEM INJURY RELATED? IF YES PLEASE, EXPLAIN IN DETAIL**_____

**WHAT MAKES THE PROBLEM WORSE?**

STANDING WALKING RUNNING EXERCISE SHOES DAILY ACTIVITIES

**WHAT MAKES THE PROBLEM BETTER?**

_____

**NAME** _____ **DOB**_____

**DO YOU EXERCISE REGULARLY?** NO YES/HOW OFTEN _____

**DO YOU DRINK ALCOHOL? YES, HOW MANY PER DAY?** NO YES_____

**DO YOU USE RECREATIONAL DRUGS? YES, IF SO PLEASE LIST:** NO YES_____

**TOBACOO USE?**

NEVER FORMER, NUMBER OF YEARS_____ CURRENT___PACKS PER DAY/YEARS_____

OTHER TOBACCO: PIPE E-CIGARETTE SNUFF CHEW

**DO YOU HAVE ANY OF THE FOLLOWING?**

| | | | |
|---|---|---|---|
| ITCHING | LEG CRAMPING | MUSCLE/JOINT PAIN | DIZZINESS/FAINTING |
| RASH | LEG WEAKNESS | STIFFNESS | TREMORS |
| DEFORMED NAILS | CLOTS IN LEGS | BACK PAIN | SEIZURES |
| PSORIASIS | COLD FEET | REDNESS OF JOINTS | WEAKNESS |
| SKIN CANCER | VARICOSE VEINS | SWELLING OF JOINTS | NUMBNESS |
| ECZEMA | | TRAUMA | TINGLING |

**DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF YES, PLEASE LIST…**

_____

**NEW PATIENTS ONLY: MEDICATION LIST**

_____

_____

_____

_____

_____

***Ocala Family Medical Center***
2230 SW 19th Avenue Road
Ocala, FL 34471
(352) 237-4133

Dear Patient:

Welcome to Ocala Family Medical Center, Inc. Our goal is to improve your quality of life. It is our policy to charge for missed appointments at the rate of:

## Primary Care:

**New Patient Appointment**: $50.00

**Follow Up Appointment**: $50.00

## Physical Therapy

**Initial Evaluation**: $100.00

**Follow Up Appointment:** $75.00

## Specialist

**New Patient Appointment**: $100.00

**Follow Up Appointment**: $75.00

**Missed Procedures**: $100.00

## Radiology

**CT Appointment:** $100.00

**MRI Appointment**: $100.00

**Nuclear Appointment**: $100.00

**Ultrasound Appointment**: $100.00

Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep an appointment, please call (352) 237-4133 to reschedule your appointment at least 24-hours in advance.

Sincerely,
The Staff of Ocala Family Medical Center

I have read and understand the above no show policy.

| Print Name | Date of Birth |
|---|---|
| Signature | Date |

Effective: 02/02/2024