PODIATRY

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1633 Medical Center Point, C/S, CO 80907 • 719-447-1000

DaVita Medical Group

Patient Name_____ Age _____ Today's Date_____

Patient's Date of Birth_____ Sex ____ M _____ F MRN# _____

PREVIOUS MEDICAL VISITS

Provider who referred you to us _____Primary provider _____

Former podiatrist _____ Reason for seeing him/her _____

_____

Have you previously had physical therapy (circle one)? Yes No If yes, when? _____
Condition requiring therapy: _____

PRIMARY HEALTH CONCERN

Why are you seeing us today? _____

_____

How long have you had this foot/ankle problem? _____
Have you received treatment for this problem (circle one)? Yes No If yes, what? _____
Have you ever been diagnosed with sleep apnea (circle one)? Yes No If yes, when? _____

PREVIOUS MEDICAL HISTORY

Current Medications (please include prescriptions, over-the-counter, vitamins and/or herbals)

Medication	Strength	Taken for how long?	Reason

If you are female, are you pregnant? _____

Allergies to medication or food (circle one): No Yes If yes, please list the medications and the reactions:

_____

Have you ever had a DVT or PE (Blood Clot)? No Yes

Patient signature _____ **Date** _____

Reviewed by _____ **Date** _____

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PREVIOUS MEDICAL HISTORY (cont.)

Medical Problems	Surgeries/Hospitalizations/Complications	Year

FAMILY HISTORY

Member	**Alive**	**Deceased**	**Age**	**Medical problems or cause of death**
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Work: In the home _____ Student _____ Employed (Occupation): _____
Unemployed (How long? _____)

Marital Status (circle one): Single Married Divorced Separated Widowed

Do you have children (circle one): No Yes If yes, how many? _____
Do you live alone? No Yes

How often do you exercise? Daily Weekly Monthly Rarely Never
What type of exercise?: _____
Are you on a special diet? No Yes If yes, describe: _____

History of substance abuse?: No Yes If yes, what?: _____

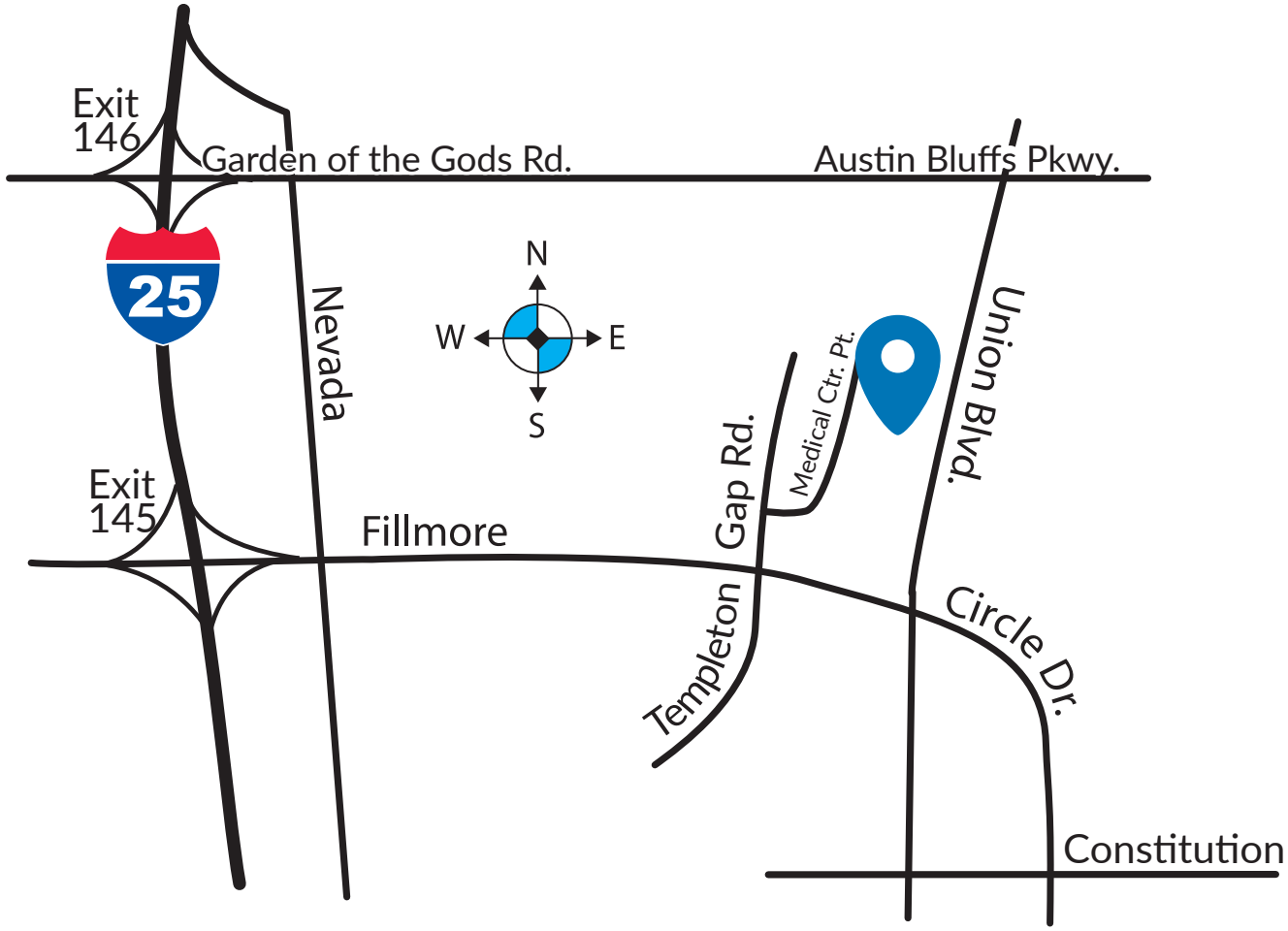
Current Smoker? No Yes _____ packs/ day / week for _____ years
Quit Smoking: This year <1year >5 years >10 years
Previously smoked: _____ packs per day/week for _____ years

Drink alcohol: Daily 1-2x/week 1-2x/month 1-2x/year Never
Drug use: Never In the past Type/Frequency: _____

Patient Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____

DaVita Medical Group - Medical Center Point



*map not to scale

1633 Medical Center Point

Located on the northwest corner of Fillmore & Union

DaVita Medical Group