

PODIATRY

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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 _____

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

