OPTUM®

1633 Medical Center Point
Colorado Springs, CO 80907
1-719-447-1000 TTY **711**

Podiatry

Patient's 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 (check 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 (check one)? ☐ Yes ☐ No If yes, when? _____

Have you ever been diagnosed with sleep apnea (check 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? ☐ Yes ☐ No

Allergies to medication or food (check 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's name: _____ Date: _____/ _____/ _____

Reviewed by: _____ Date: _____/ _____/ _____

Previous medical history (continued)

Medical problems	Surgeries/Hospitalizations/Complications	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family history

Member	Alive	Deceased	Age	Medical problems or cause of death
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____

Social history

Work: ☐ In the home ☐ Student ☐ Employed (Occupation): _____

☐ Unemployed (How long? _____)

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have children? (check 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 ☐ < Year ☐ > 5 years ☐ > 10 years

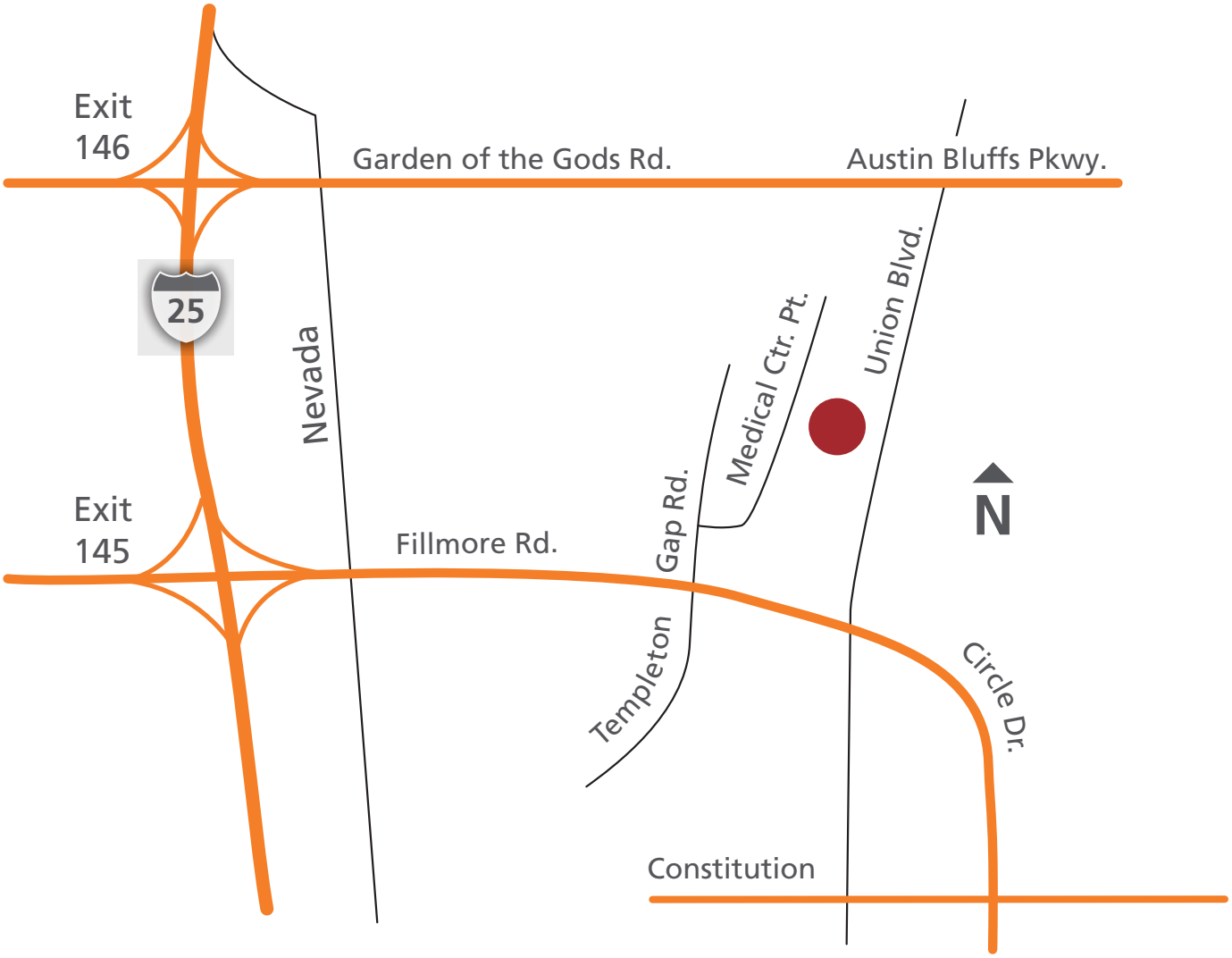
Previously smoked: _____packs per day/week for _____ years

Drink alcohol: ☐ Daily ☐ 1–2x/week ☐ 1–2x/month ☐ 1–2x/year ☐ Never

Drug use: ☐ Never ☐ In the past Type/Frequency _____

Patient's signature: _____ Date: _____/ _____/ _____

Reviewed by: _____ Date: _____/ _____/ _____



1625 Medical Center Point
Located on the northwest corner of Fillmore & Union

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