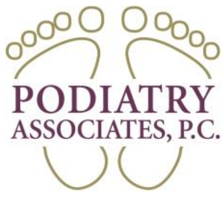


www.footdoctorscolorado.com

Castle Pines Foot and Ankle Clinic, PC
Castle Pines Physical Therapy and Spa, PC
7505 Village Square Drive, Suite 101, Castle Pines, CO 80108
P: 303-805-5156

Parker Foot and Ankle Clinic, PC
9397 Crown Crest Boulevard, Alpine Bldg., Suite 311
Parker, Colorado 80138
Fax: 303-805-5157

Name: _________________________ Date: _____________

INITIAL PODIATRIC HISTORY

Description of Symptoms: ________________________________

____

Injury? O Yes O No Date of Injury? ________________ O N/A

When did your pain/disability start? ________________________

What makes it hurt? ___________________________________

____

What makes it better? __________________________________

____

Do you have any other problems with your feet or ankles?

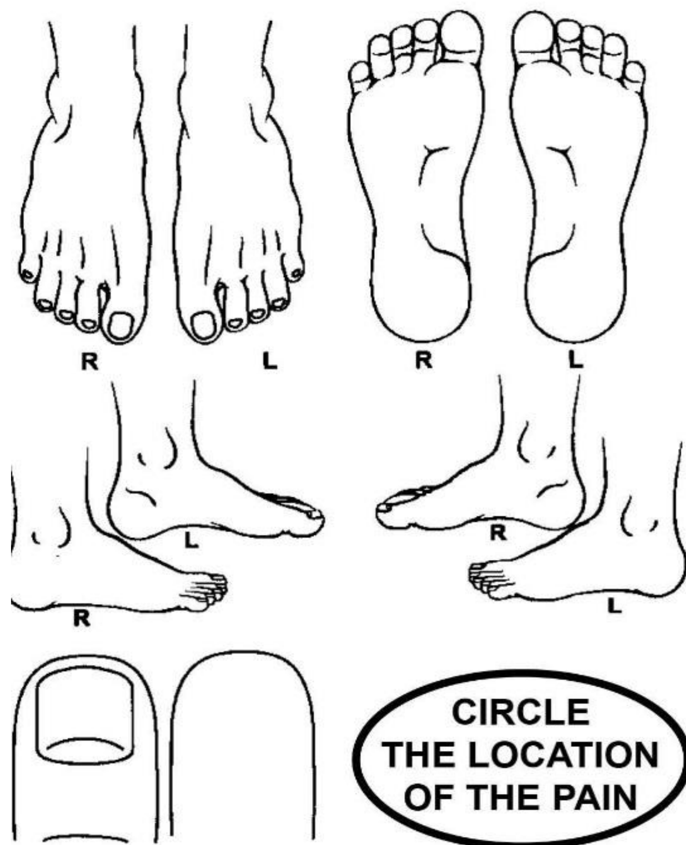
____

____

What treatments have you tried?

____

____



MEDICAL HISTORY

List all Medical conditions:

____

List any serious injuries and the age at which they occurred: _______________________________

____

List all prior surgeries:____

List any allergies and type of reaction: _______________________________________

____

Pharmacy: ___________________Address: ______________________________ Phone: _______________

Name: ___________________________ Date: ______________

List any medications you take on a daily basis-include pills, injectables, and vitamins:____

____

Tobacco Use: O Current O Former O Never If smoker: How many years and how much per day: ____________________

Alcohol Use: O Yes O No How much do you drink: O Social Drinker O Moderate 1-2 per day O More than 2 per day

How often do you exercise: O Exercise Regularly O Moderate 1-3 times a week O Occasionally O Never

Height: ______________ Weight: _____________ Shoe Size: ______________ Shoe Width: _____________

Are you pregnant? O Yes O No Delivery Date? ________________________

Family History: Is there a Family History of any of these disorders?

O Heart O Migraines O Cancer O Kidney O Spine O Diabetes O Gout
O Arthritis O Hypertension O Liver O Mental O Allergies O Other

General: Date of last exam? ________________________

O Weight Change O Fatigue O Sweating/Night sweats O Weakness

Gastrointestinal:

O Appetite Change O Indigestion O Hernia O Blood in stool or black stool
O Constipation O Change in Bowel Habits O Ulcer O Nausea, vomiting, diarrhea
O Hepatitis O Gall Bladder Problems O Painful Swallowing O Food intolerance or avoidance
O Abdominal Pain O Liver Problems

Genitourinary:

O Painful Urination O Prostate Problem O Frequency O Urgency/incontinence

Neurologic:

O Fainting O Convulsions O Numbness/Tingling O Gait/Coordination Problem
O Speech Problems O Paralysis/Weakness

Eyes:

O Vision/Glasses O Blurring O Floaters O Double Vision
O Pain O Discharge O Cataract O Glaucoma

Ears/Nose/Throat:

O Ringing O Difficult Hearing O Frequency Infection O Sinusitis
O Bleeding O Discharge O Obstruction O Postnasal Drip
O Sores O Gum Bleeding O Teeth O Hoarseness
O Dentures O Taste

Cardio-vascular:

O Chest Pain O Pain over Heart O Leg Pain on Walking O Tiredness
O Heart Attack O High Blood Pressure O Rapid Heart Beat O Weakness
O Varicose Veins O Heart Problems O Night Sweats O Hands Swelling
O Feet Swelling

1.15.14

Name: _________________________ Date: _____________

Respiratory:

O Persistent Cough	O Difficult Breathing	O Bronchitis	O Coughing
O Lung Problems	O Coughing Blood	O Emphysema	O Asthma
O Wheezing	O Hay Fever	O Shortness of Breath	

Integument:

O Itching	O Psoriasis	O Bruises	O Deformed Nails
O Skin Rash	O Abrasions	O Ulcerations	O Birth Marks
O Moles	O Discolorations	O Skin Cancers	O Eczema
O Hives			

Musculoskeletal:

O Arthritis	O Stiffness	O Club Foot	O Muscle Pain
O Joint Disease	O Bursitis	O Fractures	O Sciatica
O Sprains			

Allergies:

O Penicillin	O Morphine	O Adhesive Tape	O Aspirin
O Sulfa Drugs	O Antibiotics	O Any Foods	O Codeine

Hematologic:

O Bleeding Disorder	O Take Coumadin	O Anemia	O Jaundice
O Take Aspirin			

Do you have any other medical conditions we did not ask? ____

Signature: ____ Date: ______________________________________

1.15.14