PIKES PEAK
FOOT & ANKLE CLINIC

Medical History

PLEASE FILL OUT THIS FORM COMPLETELY AND PLACE N/A IF NOT APPLICABLE TO YOU

NAME:____DATE OF BIRTH:____/_____/____

Describe your current foot/ankle problem:____

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How long have you had this problem:____Days_____Weeks_____Months_____Years

Have you tried treating this yourself? If Yes How?__________________________________

____

Family Physician:_________________________________Last Visit Date:_____/_____/____

Allergies: (Please Circle any Allergies)   NONE

Adhesive Tape   Codine   Iodine   Local Anesthetics   Penicillin   Sulfa   NSAID's

Other:____

Family Medical History: Please list any significant family medical history)_______________

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Smoking History: (   ) Never Smoked. (   ) Past Smoker   (   ) Current smoker #/Day________

Alcohol Use: (   ) No   (   ) Yes. How many/how often:____________________________

Previous Surgeries: (Please list procedure and dates)_______________________________

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Height:____________________ **Weight:**________________**Shoe Size:**_________________

Please Check YES or NO to indicate if you have any of the following

	Y	N		Y	N		Y	N		Y	N
Aids/HIV			Circulatory problems			Hepatitis			Radiation treatment		
Allergies to anesthetics			Depression			High blood pressure			Respiratory disease		
Anemia			Diabetes			Jaundice			Rheumatic fever		
Angina			Dialysis			Kidney problems			Rheumatoid arthritis		
Arthritis			Ear problems			Liver disease			Sinus problems		
Artificial heart valves			Epilepsy			Low blood pressure			Skin cancer		
Artificial joints			Eye problems			Nervous problems			Stroke		
Asthma			Fainting			Neuropathy			Swollen neck glands		
Back problems			Glaucoma			Osteoporosis			Thyroid problems		
Bleeding disorders			Gout			Phlebitis			Tuberculosis		
Cancer,			Heart attack			Pneumonia			Ulcers		
Cataracts			Heart disease			Prostate problems			Varicose veins		
Chemical dependency			Heart surgery			Psoriasis			Venereal disease		
Chronic diarrhea			Hemophilia			Psychiatric care			Other,		

Medications: (Please list current medications including over-the-counter medications, such as vitamins, supplements, and oral contraceptives

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Review of Body Systems

Please Circle if you have any of the following

Constitutional:	**Weight gain**	**Weight loss**	**Fever**	**Night sweats**	**Fatigue**
Eyes:	**Blurred vision**	**Dry eyes**	**Irritations**	**Vision change**	
Ear, Nose, Throat:	**Difficulty hearing**	**Sinus problems**	**Sore throat**	**Cough**	**Breathing problems**
Cardiovascular:	**Chest pain**	**Heart murmur**	**Palpitations**		
Respiratory:	**Shortness of breath**	**Coughing**	**Wheezing**	**Sleep apnea**	
Gastrointestinal:	**Nausea**	**Vomiting**	**Abdominal pain**	**GERD**	**Diarrhea**
Genitourinary:	**Frequent urination**	**Incontinence**	**Difficulty urinating**	**Discharge**	
Musculoskeletal:	**Muscle aches**	**Muscle weakness**	**Joint pain**	**Back pain**	**Swelling**
Skin:	**Dry skin**	**Itching**	**Growths/Lesions**	**Rash**	
Neurologic:	**Seizures**	**Numbness**	**Tingling**	**Burning**	Headaches
Psychological:	**Depression**	**Sleep disturbances**	**Substance abuse**	**Restless sleep**	

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Hematologic:	**Swollen glands**	**Blood thinners**	**Excessive bleeding**	**Easy bruising**	

Comments:____
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Consent: I Attest that the information I provided regarding my medical history is true and correct, to the best of my knowledge. I give permission to the doctor to administer any treatment or procedure that may be deemed necessary in this and subsequent visits.

Signature of Patient or legal guardian:_____________________________ Date:___________