FRONT RANGE
PODIATRY
8151 Southpark Lane, Unit 250
Littleton, CO 80120
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MEDICAL HISTORY FORM
Form is to be completed by adult patient or patient's parent/legal guardian/power of attorney.

Demographics

Patient Full Name ____ DOB _____________

Street Address ____ Unit__________

City ________________________________ State _________ Zip Code _________________

Home Phone Number ___________________ Mobile Phone Number ___________________

Email Address (please print clearly) ____

Primary Care Physician ____

Language_______________________ Race______________________________

Ethnicity

- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino/Spanish
- ☐ Mexican
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard
- ☐ Latin American / Latin, Latino
- ☐ Not Hispanic or Latino

Marital Status

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Partner

How did you hear about us?

- ☐ Google
- ☐ Other Online Source (Where? ____________________)
- ☐ Patient in the Practice/Word of Mouth
- ☐ Hospital
- ☐ Primary Care Physician (Who? ____________________)
- ☐ Insurance Company
- ☐ Specialist Physician (Who? ____________________)
- ☐ Other, please specify ___________________________

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Circle any medical conditions that you have or have had in the past

AIDS/HIV	Edema	Organ Transplant
Anemia	Fibromyalgia	Osteoporosis
Arthritis	Foot Deformity	Pacemaker
Artificial Joints	Frost Bite	Peripheral Vascular Disease (PVD)
Asthma	Gout	Polio
Back Pain	Headaches	Pulmonary Embolism (PE)
Bleeding Disorder	Heart Disease	Raynaud's Disease
Blood Clot	Hepatitis	Rheumatoid Arthritis (RA)
Cancer	Hernia	Seizures/Epilepsy
Coronary Artery Disease (CAD)	Hypertension	Stroke
Deep Vein Thrombosis (DVT)	Kidney Disease	Substance Abuse
Diabetes	Leg or Foot Ulcers	Thyroid Problems
Dialysis	Liver Disease	Tuberculosis
Dyslipidemia	Lung Disease	Varicose Veins

List all surgeries in the past 10 years with approximate dates (fill in below) or ☐ None

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

List all medications along with dosage. Attach additional forms if more space is needed or ☐ None

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Check all allergies that apply:

☐ **None** ☐ Codeine ☐ Nickel ☐ Demerol ☐ Cipro ☐ Sulfa ☐ Aspirin ☐ Penicillin

☐ Latex ☐ Iodine ☐ Eggs ☐ Bees/Wasps ☐ Local Anesthetic ☐ Food __________________

☐ Other __________________

Social History:

Is there a possibility of being pregnant? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No Do you use tobacco? ☐ No ☐ Cigarette ☐ Vape How many per day? ___________ How many years? ___________ ☐ Formerly, quit _____ years ago	Do you drink alcohol? ☐ Yes ☐ No How much? ___________________ How often? ___________________ Do you use recreational drugs? ☐ Yes ☐ No If yes, which drugs? _____________	Shoe Size _____________________ ☐ Men's ☐ Women's ☐ Child's ☐ Narrow ☐ Medium ☐ Wide Height _________ Weight _________