COLORADO FOOT & ANKLE WELLNESS

Dr. Joe Dahlin, DPM, ABFAS

Legal Name ___________________________________ Preferred Name ____

Date of Birth _____/______/______ Age: _______ Sex: □ Male □ Female □ N/A

Address ____ City ____________________ State ______ Zip_________

Preferred Phone #: _____-_____-______ Alt #: _____-_____-______

Email ____ □ Opt-in to COFAW Newsletters (several a year)

Marital Status: □ Single □ Married □ Divorced □ Widowed Occupation: ___________________________________

Your Primary Care Physician is ___________________________________ Date Last Seen by PCP _____/______/______

Primary Language _____________________________ Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □White

Race: □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander

How did you learn of Colorado Foot & Ankle Wellness? □ Current Patient

□ Physician □ Social Media/Internet □ Yellow Pages □ Insurance Manual □ Newspaper/Mail □ Friend/Relative

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PLEASE READ CAREFULLY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGES TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. I AUTHORIZE COFAW TO FURNISH INFORMATION TO MY/OTHER DOCTORS/HEALTH INSTITIONS CONCERNING MY ILLNESS AND TREATMENTS AS NECESSARY FOR THE WELLBEING OF THE PATIENT WITH THEIR PRIOR NOTICE AS DISCUSSED IN APPOINTMENT TO PROVIDE FURTHER PROPER CARE OF THE PATIENT. I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

MEDICAL RECORDS: I UNDERSTAND THAT MY MEDICAL CHART IS THE PROPERTY OF THE PRACTICE AND THAT NO ORIGINAL NOTES OR X-RAYS WILL BE RELEASE. HOWEVER, I UNDERSTAND THAT I HAVE A RIGHT TO ALL INFORMATION IN MY CHART AND THAT INFORMATION WILL BE PROVIDED TO ME WITHIN THREE BUSINESS DAYS ONCE A PROPERLY EXECUTED MEDICAL RECORDS RELEASE HAS BEEN RECEIVED BY THE PRACTICE. I UNDERSTAND THAT THERE MAY BE A CHARGE FOR A COPY OF MY RECORDS AND/OR X-RAYS.

*Signature: ____ Date: _____/______/_____

Relationship: □ Self □ Guardian □ POA □ Other __________________________________

PLEASE COMPLETE ALL OF THE FOLLOWING

What Concerns Would You Like to Address Today: □ Left □ Right □ Both

____

____

Height ________ Weight ________ Shoe Size ________ □ Narrow □ Regular □ Wide

____

Hobbies/Activities: ____

MEDICAL HISTORY: Have you been diagnosed or notified of any of the following conditions? Please check only those that apply and circle where appropriate. This is to provide you the upmost of care possible. Thank you!

□ High Blood Pressure
□ High Cholesterol
□ A. Fib/Heart Condition
□ Stroke
□ Blood Clot: Location _________
□ Heart Attack
□ Heart Murmur
□ Peripheral Vascular Disease
□ Cirrhosis
□ Hepatitis A / B/ C
□ HIV/AIDS
□ Liver Disease

□ GERD/Acid Reflex
□ Abnormal Kidney Function
Dialysis ___Y ____N
□ Anxiety
□ Depression
□ Dementia
□ Multiple Sclerosis
□ Seizures
□ Parkinson's
□ Neuropathy
□ COPD
□ Asthma

□ Sleep Apnea
□ Oxygen / Liters _____________
□ Arthritis Type _______________
□ Osteoporosis
□ Back Pain
□ Gout
□ Abnormal Scar Formation
□ Cancer Specify ______________
□ Glaucoma
□ Thyroid
□ Diabetes Type I / ll
Last HbA1C _____

Are you Currently Pregnant? □ Yes □ No

Anything else our physician should know about your medical history:

____

List ALL medications you are currently taking: □ See Attached List

____

____

List ALL allergies to medications / food: □ See Attached List

____

List ALL previous surgeries and any reactions to anesthetics: □ See Attached List

____

____

Have you ever used tobacco products? Y / N □ Chew □ Smoke; How many per day? _____ □ Previous tobacco use

How many alcoholic drinks do you have per week? ______

Do you use any illegal/illicit drugs besides prescription medication? □ Yes □ No

Do you use marijuana products? □ Yes □ No How frequently? ____________________

Immediate Family History of: (List Who – Excluding Yourself)

Cancer ____________________________________ High Blood Pressure ______________________________

Heart Condition _____________________________ Diabetes _______________________________________

Are you CURRENTLY experiencing any of the following symptoms (please CIRCLE): Fever, chills, nausea, vomiting, menopause symptoms, weight loss, weight gain, lumps, sores, rashes, dizziness, eye sight changes, headaches, problem swallowing, ringing ears, problem breathing, pneumonia, asthma, chest pain, chest tightness, heart palpitations, heart murmur, abdominal cramping, bloody stools, diarrhea, stomach burning, discharge, pain with urination, limb deformity, loss of consciousness, loss of use of any limb, blackouts, seizures, night sweats, excessive thirst, frequent night urination, excessive hunger, excessive bleeding, excessive bruising.

Other, please list:
____

Signature: ____ Date: ___________________________________