Health History Questionnaire For: ______________________ Date ______________

I prefer to be addressed by ______________ Occupation ______________

Medical Record Number ______________ Date of Birth ______________

Date Last Seen by PCP ______________

Have you ever had any of the following conditions? (Check all that apply)

☐ Stroke	☐ Venous Disease	☐ Heart Condition
☐ Phlebitis	☐ Peripheral Artery Disease	Type ______________
☐ Anemia	☐ Kidney Disease	☐ Glaucoma/Macular Degeneration
☐ Diabetes	☐ Osteoporosis	☐ Glaucoma/Macular Degeneration
☐ Gout	☐ Lyme's Disease	☐ Keloid/Thick Scar
☐ Sciatica	☐ Headaches	☐ Alzheimer's
☐ Arthritis	☐ Depression / Anxiety	☐ Rheumatic Fever
☐ Epilepsy	☐ Nerve Disorder	☐ Hearing / Ear Disorder
☐ Asthma	☐ Lung Disease	☐ Psychiatric Disorder
☐ Hepatitis	☐ Liver Disease	☐ Tuberculosis
☐ Cancer ______________	☐ Stomach Ulcer	☐ Thyroid Problem
☐ Heart Attack	☐ High Blood Pressure	☐ Other ______________
		☐ None of These

Are you slow to heal after cuts? ☐ Yes

Abnormal bruising, bleeding or scarring? ☐ Yes

Do you have vascular grafts/stents? ☐ Yes

Do you have joint implants? ☐ Yes

Do you have replacement heart valves? ☐ Yes

Are you under active chemotherapy? ☐ Yes

Have you had any other serious illness? ☐ Yes ______________

Have you been hospitalized or been under medical care over 24 hours? ☐ Yes

Explain ______________

Have you had any surgery (if yes explain below with dates)? ☐ Yes

____

____

____

Did you ever smoke? ☐ Yes ☐ No Packs/Day ____ Years ____

Current smoker? ☐ Yes ☐ No Packs/Day ____ Years ____ Quit ____ When? ______

Alcoholic Beverages? ☐ Yes ☐ No If yes, how often ____ Quit ☐ Yes ☐ No

Recreational Drugs? ☐ Yes ☐ No If yes, how often ____ Quit ☐ Yes ☐ No

Please List any Food or Drug Allergies (latex, penicillin, sulfa drugs, shrimp, Iodine), with reaction & severity

☐ NKDA *(No Known Drug Allergies)*

Please List any Medication/Dose or Supplements you are taking including any over the counter medication

☐ See attached listing

______________ ______________ ______________

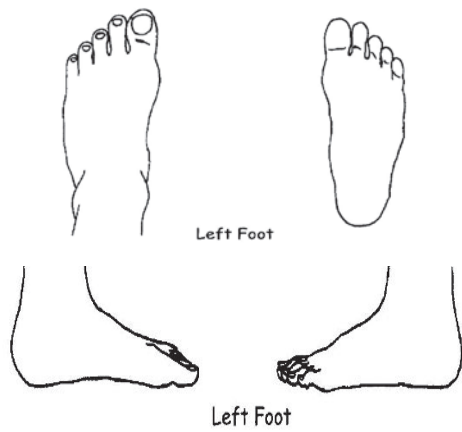
______________ ______________ ______________

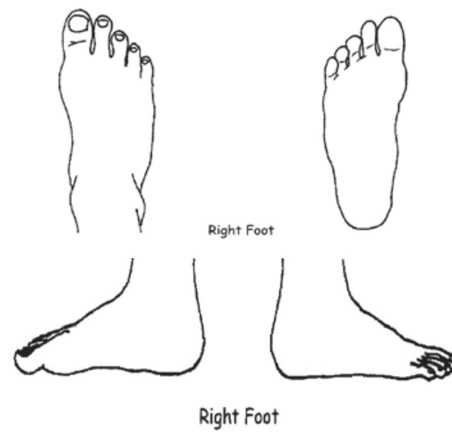
Family Health History: Please check any that apply to your Mother, Father, Brother and/or Sister

Diabetes	M ☐	F ☐	B ☐	S ☐	Cancer	M ☐	F ☐	B ☐	S ☐
Arthritis	M ☐	F ☐	B ☐	S ☐	Heart Attack	M ☐	F ☐	B ☐	S ☐
Stroke	M ☐	F ☐	B ☐	S ☐	High Blood Pressure	M ☐	F ☐	B ☐	S ☐

Patient Signature ______________________

Doctor Signature ______________





Doctor Signature ____________

Medical Record Number ____________

Please mark the location of your **First** foot problem with a **# 1**

☐ Shooting Pain ☐ Throbbing Pain ☐ Sharp Pain
☐ Burning Pain ☐ Itching ☐ Aching Pain
☐ Tenderness ☐ Dull Pain ☐ Tingling / Numbness

How long ago did the problem (pain) start? ______ days ______ weeks ______ months ______ years

Does the pain occur while walking? ☐ Yes ☐ No

Severity ☐ Light ☐ Moderate ☐ Strong

Is the problem work related? ☐ Yes ☐ No Date of Injury________ Date reported to Employer________

List previous medical treatments for this issue by physician or home remedies

____

____

Please mark the location of your **Second** foot problem with a **# 2**

☐ Shooting Pain ☐ Throbbing Pain ☐ Sharp Pain
☐ Burning Pain ☐ Itching ☐ Aching Pain
☐ Tenderness ☐ Dull Pain ☐ Tingling / Numbness

How long ago did the problem (pain) start? ______ days ______ weeks ______ months ______ years

Does the pain occur while walking? ☐ Yes ☐ No

Severity ☐ Light ☐ Moderate ☐ Strong

Is the problem work related? ☐ Yes ☐ No Date of Injury________ Date reported to Employer________

List previous medical treatments for this issue by physician or home remedies

____

____

Have you ever been treated for or experienced any conditions of the foot and/or ankle?
(leg/foot ulcer, cramps in legs/feet, fungal nails, sprains)? Explain ____________________

____

Shoe Size ________________

Did you previously, or do you wear: Who provided them? Podiatrist ☐ Orthopedist ☐ Store ☐

Shoe Inserts ☐ Yes ☐ No Still using them ☐ Yes ☐ No Did they help ☐ Yes ☐ No
Orthotics ☐ Yes ☐ No Still using them ☐ Yes ☐ No Did they help ☐ Yes ☐ No

Are your first steps out of bed painful? ☐ Yes ☐ No Does pain subside? ☐ Yes ☐ No
Do you get leg cramps during the day? ☐ Yes ☐ No at night? ☐ Yes ☐ No

Patient Signature ______________________________ Date ____________