Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE-PODIATRY

Welcome to our office. All the following questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your knowledge. These questions will assist us in your comprehensive and efficient medical care.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐ Widowed	
Primary and referring doctor and address:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	

Circle any medical problems that other doctors have diagnosed

AID/HIV	Diverticulosis	Psychiatric Care
Alcoholism	Drug Dependency	Rheumatic Fever
Anemia	Fibromyalgia	Scarlet Fever
Anorexia/Bulemia	Gout	Stroke
Arthritis	Hay Fever/Allergies	Ulcers
Asthma	Heart Disease	Other Illness:
Bleeding Disorders	Hepatitis	
Blood transfusions	High Blood Pressure	
Cancer	Kidney disease	
Colitis	Multiple Sclerosis	
Congenital Disorders	Polio	
Depression	Psoriasis	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
# of meals you eat in an average day?						
Rank salt intake	☐ Hi	☐ Med	☐ Low			
Rank fat intake	☐ Hi	☐ Med	☐ Low			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
How many drinks per week?						
Are you concerned about the amount you drink?					☐ Yes	☐ No
Have you considered stopping?					☐ Yes	☐ No
Have you ever experienced blackouts?					☐ Yes	☐ No
Are you prone to "binge" drinking?					☐ Yes	☐ No
Do you drive after drinking?					☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
☐ # of years	☐ Or year quit					
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
If not trying for a pregnancy list contraceptive or barrier method used:						

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No

Do you have vision or hearing loss?	☐ Yes	☐ No
Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
Would you like information on the preparation of these?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
☐ M ☐ F		**Grandmother** *Maternal*			
☐ M ☐ F		**Grandfather** *Maternal*			
☐ M ☐ F		**Grandm**			

		other *Paternal*		
☐ M ☐ F		**Grandfather** *Paternal*		

PODIATRY HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Heel pain/arch pain	☐ Painful corns	☐ Recent changes in weight
☐ Bunion pain	☐ Warts (top/bottom of foot)	☐ Shooting pain in feet and lower legs
☐ Flat feet	☐ Rash on foot	☐ New exercise
☐ Numbness or tingling in feet	☐ Itching of feet	☐ Ability to sleep due to foot pain
☐ Trauma or injury	☐ Hammertoes – curled toes	☐ Other pain/discomfort:
☐ Ankle pain	☐ Circulation	

Have you seen a Podiatrist prior to this appointment? If so please list name of the doctor and last seen:

_____

Please provide us with your current

Height_____ Weight_____ Shoe Size_____

X_____Date_____

Thank you very much for completing the information on this form and providing us with pertinent information for your care.