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Health History Questionnaire
(Please Print)

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(First M.I. Last):*		**DOB:**	
Your Chief Foot Complaint:			
Date of last physical exam:		**Primary or referring doctor:**	

PERSONAL HEALTH HISTORY

Height:		**Weight:**		**Blood Pressure:**		**Shoe Size:**	
Diabetic:	☐ Yes ☐ No	**Any Family History of Diabetes:**					
Cancer:	☐ Yes ☐ No	**If Yes, Please explain:**					
Subject to Prolonged Bleeding:	☐ Yes ☐ No	**If Female, Are You Pregnant?**	☐ Yes ☐ No				
Have you had an influenza vaccine?	☐ Yes ☐ No	**If 65 or older, have you had the pneumonia vaccine?**	☐ Yes ☐ No				

Significant Family Health Problems

Relationship to You	Age	Health Problem

Prescription medications, over the counter medications, vitamins, etc.. (*If you have a list, please give to receptionist)*

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Allergies to adhesive tape?	☐ Yes ☐ No	Allergies to Latex?	☐ Yes ☐ No	No Known Drug Allergies ☐

Surgeries

Year	Reason	Hospital

Check any of the following that apply:

☐ Anemia	☐ Asthma	☐ Circulatory Problems	☐ Ears/Nose/Throat	☐ Fainting
☐ Gout	☐ Heart Problems	☐ Kidney Problems	☐ Liver Problems	☐ Nerve Disorders
☐ Pneumonia	☐ Rheumatic Fever	☐ Seizures	☐ Stroke	☐ Ulcers
☐ Tumors/Growths	If yes, Please explain where and what:			
Other Problems (Please explain):				

HEALTH HABITS

Alcohol	Do you drink alcohol?	☐ Yes ☐ No		
Tobacco	Do you use tobacco?	☐ Yes ☐ No	☐ # of years	☐ Or year quit