Family Foot Health Center, PC

Patient Questionnaire

Name _____ Date: _____

Chief Complaint: _____

Statistics: Height _____ Weight: _____ Shoe Size _____

Past Medical History. Please check all that apply.

- ❑ Diabetes (Problems with blood sugar)
  Type I or Type II
- ❑ Thyroid Disorders
  Hyperthyroid or Hypothyroid
- ❑ Heart Problems
- ❑ Congestive heart failure
- ❑ Angina (chest pain) Onset _____
- ❑ Heart murmur Onset _____
- ❑ Pacemaker _____
- ❑ Anemia
- ❑ Circulation Problems
  Varicose Veins
- ❑ Blood Clots Phleb Treatment _____
- ❑ Valve Problem Please Specify
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke/TIA Onset
- ❑ Cancer: When diagnosed? What type? _____
- ❑ Seizures What Type? When was last one? _____
- ❑ Fainting
- ❑ Bleeding disorders: Please specify. _____
- ❑ Sleep apnea
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Tuberculosis: When diagnosed _____/Treatment Date ___ ___
- ❑ HIV / AIDS
- ❑ Autism: _____
- ❑ Learning Disabilities _____
- ❑ Gastrointestinal Please specify _____
- ❑ Reflux Heartburn
- ❑ Urinary or Kidney Disorders. Please specify _____
- ❑ Hepatitis: What type _____
- ❑ Cirrhosis
- ❑ Liver Disease
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Osteopenia/Osteoporosis
- ❑ Lyme Disease
- ❑ Bone Density Date _____
- ❑ Lupus
- ❑ Migraines
- ❑ Neurological Problems
- ❑ Back or neck problems
- ❑ Eye Disorders: Type _____
- ❑ Hearing Problems
- ❑ Rheumatic Fever
- ❑ Psychiatric Care
- ❑ Depression/Anxiety
- ❑ Pregnant
- ❑ Difficulty with anesthesia: What happens? _____
- ❑ Prone to scarring
- ❑ Gout
- ❑ No Past Medical History

❑ Please list any other medical conditions not listed above: _____

Allergies:

Do you have allergies to medications	Yes	No	Reaction
	[ ]	[ ]	

Please specify. _____

Latex	[ ]	[ ]	_____	Adhesive Tape	[ ]	[ ]	_____
Shellfish	[ ]	[ ]	_____	Anesthetics	[ ]	[ ]	_____
X-ray contrast / Iodine	[ ]	[ ]	_____	Other	_____		

Medications:

Please list all medications & vitamins & herbal supplements that you currently take both prescription and over the counter:

1. _____ 4 _____ 7. _____
2. _____ 5 _____ 8. _____
3. _____ 6 _____ 9. _____

Past Surgical History:

Please list any surgery that you have had and the date they were performed _____

Family History:

Does anyone in your family suffer from any of the following medical conditions? If yes, please state the person and describe the medical problem

Bleeding problems/Clotting Disorders _____ Cancer _____
Diabetes _____ Heart Disease _____
Hypertension _____ Thyroid Problems _____
Any other medical condition not listed _____

Social History:

Do you drink Alcohol? _____ If yes, What type? Beer, Wine, Liquor _____
How much do you drink? _____ How often do you drink? _____
Do you smoke? _____ Have you ever smoked? _____
If yes, how many years? _____ If yes, how much do you smoke per day? _____
If you no longer smoke, when did you quit? _____
Do you drink Coffee? _____ If yes, how much per day? _____
Do you drink Soda with caffeine? _____ If yes, how much per day? _____
Do you drink Tea? _____ If yes, how much per day? _____

Signature _____ Date _____