HEALTH HISTORY QUESTIONNAIRE

Doctor Signature _____

Patient's Full Name _____ Date _____

I prefer to be addressed as _____ 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)

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer _____
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: Type I ___ Type II ___
  Insulin: Yes ___ No ___
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Condition
  Type _____
- ☐ Hepatitis: Type A ___ B ___ C ___
- ☐ High Blood Pressure
- ☐ Keloid/Thick Scar
- ☐ Kidney Disease
  Dialysis: Yes ___ No ___
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lyme Disease
- ☐ Macular Degeneration
- ☐ Nerve Disorder
- ☐ Osteoporosis
- ☐ Peripheral Artery Disease
- ☐ Phlebitis
- ☐ Psychiatric Disorder
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Venous Disease
- ☐ 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

Do you have a pacemaker? ☐ Yes

Do you have a defibrillator? ☐ Yes

Are you under active chemotherapy? ☐ Yes

Do you have Sleep Apnea? ☐ Yes ☐ No

Do you use CPAP or BiPAP machine? ☐ Yes ☐ No

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? _____ Vape? ___ E-cigarette? ___

Alcoholic Beverages? ☐ Yes ☐ No If yes, how often ___

Recreational Drugs? ☐ Yes ☐ No If yes, how often ___

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

☐ NONE

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

☐ See attached listing

_____ _____ _____

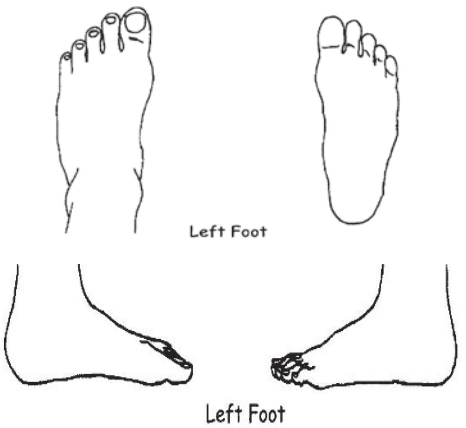
_____ _____ _____

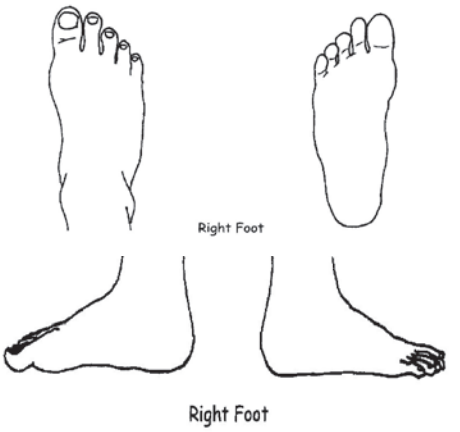
Family Health History: Please check any that apply to your Mother, Father, Brother and/or Sister

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 _____





☐ Check here for Nail Care only ☐ Fungal Nails

On diagram above, 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

_____

_____

On diagram above, 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, other)? 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 _____

Medical Record Number _____