valley foot & ankle pc

Medical History Questionnaire

Today's Date:_____ Shoe Size:_____

Name:_____ ☐ M ☐ F Date of Birth:_____Age:_____Height:_____Weight:_____

Have you seen a Podiatrist: ☐ Yes ☐ No Doctors Name: _____ Date: _____

Date of last Physical:_____ Family Doctor(s) and phone Number:_____

Medication	Dosage/Frequency

☐ I am not taking any medications including Aspirin.

Do you have any allergies to medications? ☐ Yes ☐ No
If **YES**, please list:

Medication	Reaction

List all **major illnesses** (diabetes, high blood pressure, heart attack, cancer, lung disease, etc.) or **injuries** (concussion, broken bones, etc.): _____
_____

List **all** surgeries you have had (tonsillectomy, appendectomy, heart by-pass, etc.) **Please include the year:**_____
_____

Do you CURRENTLY have any problems in the following areas? If, YES, please provide an explanation:

Problem	Yes	No	Explanation
Lower Extremity/Primary Complaint			
Skin Disorders/Infections/Skin breaks			
Circulation problems (swelling, coldness)			
Numbness/Burning/Tingling/Twitching			
Joint Pain or Deformity			
Localized Weakness/sprains or strains			
Excess fatigue with walking			
Area of redness and pain			
General Health			
Do you think you may be pregnant at this time?			
Have you, or any member of your family, had a problem with anesthesia?			
Do you take any blood thinners?			
Have you ever had a blood transfusion?			
Do you have a LATEX or TAPE allergy? (Circle one)			
Headaches			
Fever			
Sinus			
Ear Infection			
Hard of Hearing			
Hearing Aids			
Heart Attack (include date)			
Chest Pain			
Irregular Heart Beat			
Pacemaker			
Artificial Heart Valves			
Blood Clots			
High Blood Pressure			

PLEASE TURN OVER TO COMPLETE >>>>>>>>>>>>>>>>>>>>>>>>>>

Problem	Yes	No	Explanation
Bleed or Bruise Easily (do you take any blood thinners?)			
Asthma			
Emphysema			
Shortness of Breath			
Tuberculosis (active or non-active?)			
Chronic Cough			
Oxygen Use			
Sleep Apnea (CPAP?)			
Stomach or Intestinal Disease			
Hiatal Hernia			
Hepatitis (If yes, which one, A, B, or C)			
Liver Disease			
Genital			
Prostate			
Kidney (Dialysis?)			
Bladder			
Arthritis			
Wheelchair, Cane or Walker (If yes, circle one)			
Cancer (TYPE?)			
Seizures			
Fainting Spells			
Stroke			
Paralysis			
Alzheimer's Disease/ Dementia			
MRSA (current or history of)			
Anxiety			
Depression			
Insomnia			
Diabetes **(non-insulin dependant or insulin dependant, how many years?)**			
Thyroid			
HIV Positive			
Lupus or any other autoimmune disorder			
Sjorgrens			
Hay Fever			
Chronic infection or weak immune system			
Other			

FAMILY HISTORY

Please indicate which of these diseases occur in your Family members and their relationship to you:

DISEASE	Y	N	RELATIONSHIP
Bleeding disorders			
Stroke			
Gout			
Diabetes			
Heart disease			
Cancer (TYPE?)			
High blood pressure			
Other			

SOCIAL HISTORY

Martial Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you drink alcohol? ☐ Yes ☐ No

If YES: ☐ Occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day

Do you smoke? ☐ Yes ☐ No

If YES: ☐ Occasional ☐ ½ pack/day ☐ 1pack/day ☐ 1+pack/day

Patients Signature: _____ Date:_____

PLEASE DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

Dr. Signature: _____ Date:_____

History Reviewed: ☐ No changes

☐ Additions as noted above

Nurse Reviewed:_____ Date:_____