

HEALTH QUESTIONNAIRE

Last Name: _____ First: _____
 Height: _____ Weight: _____ ShoeSize: _____ D.O.B.: _____ Age: _____
 Name of family Dr.: _____ M.D./D.O. Date of last visit: _____ City: _____
YOUR OCCUPATION: _____
Who can we thank for referring you? _____

DO YOU HAVE ANY ALLERGIES OR UNUSUAL REACTION TO THE FOLLOWING (nausea, rash, rapid heartbeat, etc.) **NONE**
 (Check ALL that apply. List name of medication and reaction if known)

- | | |
|---|--|
| <input type="checkbox"/> Local anesthetics _____ | <input type="checkbox"/> Demerol _____ |
| <input type="checkbox"/> Penicillin _____ | <input type="checkbox"/> Iodine _____ |
| <input type="checkbox"/> Sulfa _____ | <input type="checkbox"/> Adhesive Tape _____ |
| <input type="checkbox"/> Other antibiotics (Name) _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Aspirin _____ | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Anti-inflammatory _____ | <input type="checkbox"/> Metals _____ |
| <input type="checkbox"/> Codeine _____ | <input type="checkbox"/> Other _____ |

MEDICATIONS: (Please list name including non-prescription medications) **NONE**

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart: _____ | <input type="checkbox"/> Blood Thinner: _____ | <input type="checkbox"/> Antibiotic: _____ |
| <input type="checkbox"/> Blood Pressure: _____ | <input type="checkbox"/> Birth Control: _____ | <input type="checkbox"/> Diet Medications: _____ |
| <input type="checkbox"/> Diuretic: _____ | <input type="checkbox"/> Stomach/Ulcer: _____ | <input type="checkbox"/> Herbal Supplements: _____ |
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cholesterol: _____ | <input type="checkbox"/> Anxiety/Depression: _____ | |

Have you been hospitalized in the last 2 years? Yes No Why? _____

MEDICAL HISTORY: HAVE YOU EVER HAD (Check ALL that apply)

- | | |
|---|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Depression / Nervous Disorder _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Epilepsy / Seizures / Stroke _____ |
| <input type="checkbox"/> Heart Disease / Heart Attack _____ | <input type="checkbox"/> Arthritis / Gout _____ |
| <input type="checkbox"/> Bleeding Disorders _____ | <input type="checkbox"/> Tumors or Cancer (TYPE) _____ |
| <input type="checkbox"/> Phlebitis / Blood Clots / DVT _____ | <input type="checkbox"/> HIV Exposure (AIDS) _____ |
| <input type="checkbox"/> Any Kidney Disease _____ | <input type="checkbox"/> Injury to Feet, Ankles, Legs or Back _____ |
| <input type="checkbox"/> Any Liver Disease / Hepatitis _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Asthma / COPD / Emphysema _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stomach / Ulcer / Colitis / GERD _____ | |
| <input type="checkbox"/> Neuropathy _____ | |

SURGICAL HISTORY: (List all and approximate year and any complications) **NONE**

- | | |
|-----------|-----------|
| (1) _____ | (4) _____ |
| (2) _____ | (5) _____ |
| (3) _____ | (6) _____ |

FAMILY AND SOCIAL HISTORY:

- Are you pregnant? _____ Yes No
 Is there a family history of diabetes? _____ Yes No
 Is there a family history of hypertension? _____ Yes No
 Is there a family history of heart disease? _____ Yes No
 When was your last tetanus immunization? _____
 Do you smoke? Yes No Quit _____ packs a day
 Do you use any other tobacco products? Yes No What? _____
 Do you use alcohol? Yes No _____ occ. socially freq.
 Do you take any addicting drugs? _____ Yes No

PHYSICIAN ONLY

Signature _____ Date: _____
 (Patient or Legal Guardian)

IF YOU HAVE ANY QUESTIONS ABOUT THE INFORMATION WE ARE REQUESTING, PLEASE ASK. THIS INFORMATION WILL ASSIST THE DOCTOR IN PROVIDING YOU WITH THE SAFEST AND MOST EFFECTIVE CARE POSSIBLE.