Patient Health History Questionnaire

NAME (LAST, FIRST, M.I)_____**DATE:**_____
DATE OF BIRTH: _____

What is the primary reason for you visit? _____
_____
_____

Any past treatments? _____
_____
_____

Duration of problem: Days_____ Weeks_____ Months_____
Severity of pain on a scale of 1-10, (10 being the most severe) 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Please list any operations/ surgeries including foot and ankle with approximate dates:
_____
_____

Please list any hospitalizations with cause, approximate date: _____
_____
_____

Do you have any allergies to medications? Y/ N If answer YES, please list and describe what happened when you took that medicine.
_____

Please list any chronic medical conditions (e.g. High blood pressure, Diabetes etc.):_____
_____
_____

Please list any family history of disease or illness:
_____

Please list medications you are currently taking with dosage: _____
_____
_____

Please check the following areas if you currently have any problems or related complaint:

[ ] **General Health** (fever, weight loss, malaise)	[ ] **Musculoskeletal** (arthritis , osteoporosis)
[ ] **Cardiovascular**(heart attack, irregular heartbeat, chest pain)	[ ] **Skin** (eczema, psoriasis, acne)
[ ] **Respiratory** (asthma ,emphysema ,shortness of breath)	[ ] **Neurologic** (stroke, seizures)
[ ] **Gastrointestinal** (gastric reflux, ulcers ,difficulty swallowing ,abdominal pain, bleeding ,liver disease	[ ] **Psychiatric** (depression, mania, schizophrenia)
[ ] **Genitourinary** (prostate problems, incontinence)	[ ] **Endocrine** (thyroid, diabetes)
[ ] **Allergic/Immunologic** (immune deficiency, known environmental allergies	[ ] **Eyes** (glaucoma, cataracts, blurred vision)

Do you smoke? Y / N If yes, how much (i.e. packs/day_____ and how many years _____
Do you regularly consume alcoholic beverages? Y/ N If yes, how many drinks daily? _____

Office use only I have reviewed the above information with the patient. Initials: