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LAKEVILLE & DAKOTA FOOT CLINICS

HEALTH QUESTIONNAIRE: Please check and/or circle any of the following health problems you may have had.

Childhood diseases: ___Measles ___Mumps ___ Chickenpox
____ Anemia
____ Pneumonia
____ Diabetes
____ High blood pressure
____ Low blood pressure
____ Heart problems (i.e. abnormal rhythm, heart murmur, heart attack, congestive heart failure)
____ Stroke
____ Stomach ulcer (current, resolved)
____ Liver problems (i.e. hepatitis, cirrhosis)
____ Kidney problems (i.e. stones, failure, infections)
____ Circulation problems (i.e. hardening of arteries, varicose veins, poor circulation)
____ Blood problems (i.e. clotting disorder, hemophiliac)
____ Difficulty healing
____ HIV, AIDS, AIDS related illness
____ Nervous disorders (i.e. anxiety, depression)
____ Respiratory problems (i.e. asthma, bronchitis, T.B., emphysema)
____ Other (please specify) ___________________________

____ Rheumatic fever (residual complications i.e. heart murmur)
____ Osteoarthritis (wear and tear)
____ Rheumatoid Arthritis (inflammatory)
____ Gout
____ Phlebitis (clots in legs)
____ Neurological problems (i.e. epilepsy, Parkinson's, M.S., or other neurologic disease)
____ Cancer
____ Back problems (i.e. arthritis, ruptured disc, pinched nerves)
____ Hip/knee/leg problems (i.e. fractures, sciatica, arthritis)
____ Swelling in feet or ankles
____ Numbness or burning in feet or ankles
____ Foot or ankle ulcers
____ Foot or ankle fractures
____ Prior foot surgery
____ Problems with bleeding when cut
____ Skin problems (i.e. acne, psoriasis, cellulitis)
____ Eye problems (i.e. glaucoma, cataracts, astigmatism, diabetic retinopathy, macular degeneration)
____ Problems with scarring
____ Other (please specify) ______________________________

Do you have any contagious diseases (i.e. TB, HEPATITIS, AIDS, etc.)? If so, what: ________________________

Do you have a history of blood transfusion(s) or have you received blood products? YES _____ NO _____

Please list **ALL MEDICATIONS** you are presently taking. __________________ ___________________

______________ ______________ _______________ __________________ ___________________

Please check **ALL MEDICATIONS or SUBSTANCES** you are **ALLERGIC TO** and the reaction you get when taking them.

PENICILLIN ______ CODEINE _______ ASPIRIN _______ NOVOCAINE ______ IODINE ______
FOODS _________________________________ OTHER ____

Please list all surgeries and/or hospitalizations in the past ten years.

Do you have a history of sexually transmitted diseases? If so, what: ___________________________

FEMALES: To your knowledge, **ARE YOU presently PREGNANT OR BREASTFEEDING?** YES ___ NO ___

*****TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CURRENT AND CORRECT*****

_________________________________ ______________
Patient Signature Date