JOHN E. LACO, D.P.M., P.A.

LAKEVILLE & DAKOTA FOOT CLINICS - HEALTH QUESTIONNAIRE **NAME:** _____

DOB: _____

Please check and circle any of the following health problems you may have had. **AGE:** _____

PAST MEDICAL HISTORY:

Childhood diseases: ___Measles ___Mumps ___ Chickenpox

____Anemia
____Pneumonia
____Diabetes
___ High blood pressure
___ Low blood pressure
___High Cholesterol
___ Abnormal heart rhythm
___ Heart murmur
___ Heart attack
___ Congestive heart failure
____Stroke
____Hemophiliac
____ Rheumatic fever (heart murmur)
____Stomach ulcer (current)
____Acid Reflux
____Liver cirrhosis
____Liver hepatitis
____Liver failure
____Kidney stones
____Kidney failure
____Kidney infection
____Hardening of arteries
____Varicose veins
____Phlebitis (clots/legs)
____ Poor circulation
____Poor healing
____HIV, AIDS, AIDS related illness
____Anxiety
____ Depression
____Asthma
____Emphysema
____Bronchitis
____ T.B.
____Clotting disorder
____Other (please list)

____ Osteoarthritis (wear & tear)
____ Rheumatoid Arthritis (inflammatory)
_____Scleroderma
_____Lupus
_____Polymyositis
____ Gout
____ Epilepsy
____ Parkinson disease
____ M.S.
____Polio
____Cerebral Palsy
____ Cancer (type)
____ Back arthritis
____Back ruptured disc
____Back pinched nerves
____Hip/knee/leg fractures
____Hip/knee/leg sciatica
____Hip/knee/leg arthritis
____ Foot or ankle ulcers
____ Foot or ankle fractures
____ Prior foot surgery
____ Acne
____Psoriasis
____Cellulitis
____Glaucoma
____Cataracts
____Astigmatism
____Diabetic retinopathy
____Macular degeneration
____ Other (please list)

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 _____

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

_____ _____
Patient Signature Date

Health Questionnaire
Page 2

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.

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

FAMILY HISTORY: Does anyone in your family have any of the following:

____Diabetes ____Arthritis ____Cancer ____Other Diseases

____Heart Valve Pathology ____Abnormal Heart Rhythm _____Heart Attack ____Stent

____Hypertension (high blood pressure) _____Stroke

SOCIAL HISTORY:

Occupation: _____

Do you drink Coffee_____ Alcohol_____ Tobacco _____?
(Cigarettes, E-cigs, Chew, Cigars)

REVIEW OF SYSTEMS:

EAR/EYES/NOSE/THROAT

____Headaches
____Seizures
____Convulsions
____Ringing in Ears
____Dizziness
____Hard of hearing
_____Fainting Spells
_____Sore Throat
_____Blurred Vision
_____Nausea/Vomiting
____Double Vision

RESPIRARTORY

____Shortness of Breath
____Sinus Infection
____Bloody Nose
___Chronic Cough

VASCULAR

____Chest Pain
____Palpitations
____Cramps
____Varicose Veins
____Problem with bleeding

URINARY

____Frequent Urination
____Blood in Urine
____Burning w/Urination

GASTROINTESTINAL

____Excessive thirst
____Blood in Stool
____Problem Swallowing
_____Jaundice
_____Gallstones
_____Diarrhea
_____Chronic Constipation

MUSCULOSKELETAL

_____Joint Pain(specify)_____
_____Joint Stiffness(specify)_____
_____Weakness
_____Stiffness (specify)_____
_____ Problem scarring
_____ Swelling feet/ankles
_____ Numbness/ burning
Feet/ankles

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

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

_____ _____
Patient Signature Date