

LAKEVILLE FOOT CLINIC - HEALTH QUESTIONNAIRE

NAME: _____

DOB: _____

AGE: _____

Please check and circle any of the following health problems you may have had.

PAST MEDICAL HISTORY:

Childhood diseases: ___ Measles ___ Mumps ___ Chickenpox

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Osteoarthritis (wear & tear) |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheumatoid Arthritis (inflammatory) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Polymyositis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Parkinson disease |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> M.S. |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Hemophiliac | <input type="checkbox"/> Cancer (type) |
| <input type="checkbox"/> Rheumatic fever (heart murmur) | <input type="checkbox"/> Back arthritis |
| <input type="checkbox"/> Stomach ulcer (current) | <input type="checkbox"/> Back ruptured disc |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Back pinched nerves |
| <input type="checkbox"/> Liver cirrhosis | <input type="checkbox"/> Hip/knee/leg fractures |
| <input type="checkbox"/> Liver hepatitis | <input type="checkbox"/> Hip/knee/leg sciatica |
| <input type="checkbox"/> Liver failure | <input type="checkbox"/> Hip/knee/leg arthritis |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Foot or ankle ulcers |
| <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Foot or ankle fractures |
| <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Prior foot surgery |
| <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Phlebitis(clots/legs) | <input type="checkbox"/> Cellulitis |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Poor healing | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> HIV, AIDS, AIDS related illness | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetic retinopathy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> History of Covid-19 |
| <input type="checkbox"/> Bronchitis | |
| <input type="checkbox"/> T.B. | |
| <input type="checkbox"/> Clotting disorder | |
| <input type="checkbox"/> 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