

Podiatry Plus PC

HEALTH HISTORY QUESTIONNAIRE

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL
AND WILL BECOME PART OF YOUR MEDICAL RECORD.**

Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Reason for visit:			
Family or referring doctor:		Date of last physical exam:	A1C
Social Security #		Email:	
Address:		City:	St ZIP
Phone:	Cell:	Emergency Contact Name:	
Employer:	Phone:	Emergency Contact Phone:	
Profession:	Do you exercise, if so how?	Shoe Size:	
Pharmacy:		Pharmacy Phone:	
PERSONAL HEALTH HISTORY			
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Influenza		
Insurance THIS SECTION MUST BE FILLED OUT COMPLETELY			
1 st Insurance Name	Contract #	Group#	
Contract holder Name	Contract Holder DOB	Relationship to Patient	Contract Holder SS# is patient is a minor
2 nd Insurance Name	Contract #	Group #	
Contract Holder Name	Contract Holder DOB	Relationship to Patient	Contract Holder SS# if patient is a minor
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Surgeries:			
Allergies:			
FAMILY HEALTH HISTORY			
	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE SIGNIFICANT HEALTH PROBLEMS
Father			Mother
HEALTH HISTORY			
AIDS/HIV			<input type="checkbox"/> Yes <input type="checkbox"/> No
ALLERGIES TO ANESTHETICS			<input type="checkbox"/> Yes <input type="checkbox"/> No
ALLERGIES TO MEDICINE OR DRUGS			<input type="checkbox"/> Yes <input type="checkbox"/> No
ANEMIA			<input type="checkbox"/> Yes <input type="checkbox"/> No
ANGINA/ HEART DISEASE			<input type="checkbox"/> Yes <input type="checkbox"/> No
ARTHRITIS			<input type="checkbox"/> Yes <input type="checkbox"/> No
ARTIFICIAL HEART VALVES/JOINT			<input type="checkbox"/> Yes <input type="checkbox"/> No

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ASTHMA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BACK PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BLEEDING DISORDERS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CANCER	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CHEMICAL DEPENDENCY	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CHEST PAIN	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CHRONIC DIARRHEA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CIRCULATORY PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DIABETES	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EAR PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EPILEPSY	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EYE PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
FAINTING	<input type="checkbox"/> Yes	<input type="checkbox"/> No
FOOT/LEG CRAMPS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GOUT	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HEADACHES	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HEPATITIS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LOW/HIGH BLOOD PRESSURE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
NEUROPATHY	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PHLEBITIS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PSYCHIATRIC CARE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
RADIATION TREATMENT	<input type="checkbox"/> Yes	<input type="checkbox"/> No
RASH	<input type="checkbox"/> Yes	<input type="checkbox"/> No
RESPIRATORY DISEASE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
RHEUMATIC FEVER	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SHORTNESS OF BREATH	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SINUS PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> No
STROKE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SWELLING FOOT /ANKLES	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SWOLLEN NECK GLANDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TIRED FEET	<input type="checkbox"/> Yes	<input type="checkbox"/> No
THYROID PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TUBERCULOSIS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ULCERS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
VARICOSE VEINS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
VENEREAL DISEASE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
WEIGHT LOSS UNEXPLAINED	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I hereby consent and give my permission to the doctor (and the doctor's assistants) to administer and perform such procedures upon me as the doctor deems necessary. I certify that I have insurance with the company listed above and give Podiatry Plus PC permission to bill my insurance. I realize I am financially responsible for all bills. My healthcare information can be disclosed in order for my treatment to be paid and referral purposes.

Signature of Patient, Parent or Guardian or Responsible Party

Date

Print name of Patient, Parent or Guardian or Responsible Party

Relationship to Patient