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.):* ☐ M ☐ F			**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Reason for visit**:			
Family or referring doctor:		**Date of last physical exam:**	**A1C**
Social Security #		**Email address:**	
Address:		**City:** **St**	**ZIP**
Phone:	**Cell:**	**Emergency Contact Name:**	
Employer:	**Phone:**	**Emergency Contact Phone:**	

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Influenza	

Insurance

1st Insurance Name	Contract #	Group#
Contract holder Name	Contract Holder DOB Relationship to Patient	Contract Holder SS#
2nd Insurance Name	Contract #	Group #
Contract Holder Name	Contract Holder DOB Relationship to Patient	Contact Holder SS#

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	☐ Yes	☐ No
ALLERGIES TO ANESTHETICS	☐ Yes	☐ No
ALLERGIES TO MEDICINE OR DRUGS	☐ Yes	☐ No
ANEMIA	☐ Yes	☐ No
ANGINA	☐ Yes	☐ No
ARTHRITIS	☐ Yes	☐ No

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