

Oregon Foot Clinic

Health History Questionnaire

Name _____ Age _____ Birthdate _____ Date _____

Medical conditions, illnesses, injuries (e.g. Diabetes, Alcoholism, Anxiety, Cancer, Depression, Emphysema, Glaucoma, Heart Disease, Hernia, High Blood Pressure, Lung or Liver Disease, Pneumonia, Stroke, Thyroid, etc.)

_____	_____
_____	_____
_____	_____
_____	_____

Past Surgeries-(e.g. Appendix, Gallbladder, Hysterectomy, Moles, Toenails, etc.)

Type	Doctor or Hospital	Age or Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications you take (include non-prescription)

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*****Drug Allergies***** Check this box if none

Do you smoke/use tobacco? Yes No

How many packs a day? _____

How many years? _____

Previous smoker? When did you quit? _____

Do you drink alcohol? Yes No

Intake _____ drinks per week/month

Your Occupation _____

Forms of Exercise _____
