

# 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

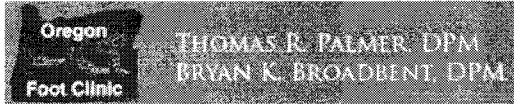
Do you smoke/use tobacco? Yes No  
How many packs a day? \_\_\_\_\_  
How many years? \_\_\_\_\_  
 Previous smoker? When did you quit? \_\_\_\_\_

\* Do you drink alcohol? Yes No  
Intake \_\_\_\_\_ drinks per week/month

Your Occupation \_\_\_\_\_

Forms of Exercise \_\_\_\_\_

\_\_\_\_\_



**PATIENT HISTORY FORM**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

Please list ALL Medical History:

PAST/ CURRENT MEDICAL PROBLEMS	

SURGERIES	

MEDICATIONS			

ALLERGIES: \_\_\_\_\_

SOCIAL HISTORY		
Do you drink alcohol? YES or NO	Do you smoke? YES or NO or QUIT	Do you exercise? YES or NO
How many drinks a day? _____	How many per day? _____	How often? _____
How many drinks a week? _____	How many years? _____	Type: _____

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY HISTORY:** Please give the following information about your immediate family.

- Does your family member have any of these health problems? (circle & complete)

	Age if Living	Age at Death	Heart Disease	Diabetes	Stroke	High Blood Pressure	High Cholesterol	Vascular Disease	Lung Disease
Mother			YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO
Father			YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO
Brothers			YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO
Sisters			YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO
Children			YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO
			YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO	YES or NO

Do you have any problems related to the following systems? (circle & complete)

CARDIOVASCULAR (Heart)		HEMATOLOGY/LYMPHATIC		ALLERGIC/IMMUNOLOGIC	
Chest pain	YES or NO	Swollen glands	YES or NO	Hay fever	YES or NO
Heart trouble	YES or NO	Blood clotting problems	YES or NO	Drug allergies	YES or NO
Heart Attack	YES or NO	Coumadin therapy	YES or NO	AIDS/HIV	YES or NO
Angina Pectoris	YES or NO	Other:		Hepatitis	YES or NO
High cholesterol	YES or NO	<b>SKIN</b>		Cancer	YES or NO
High blood pressure	YES or NO	Skin rash	YES or NO	Radiation therapy	YES or NO
Fainting	YES or NO	Athletes foot	YES or NO	Other:	
Racing of heart	YES or NO	Corns/calluses	YES or NO	<b>NEUROLOGICAL</b>	
Rheumatic fever	YES or NO	Ingrown nails	YES or NO	Stroke	YES or NO
Abnormal EKG	YES or NO	Plantar warts	YES or NO	TIA (mini-stroke)	YES or NO
Swelling of Ankles	YES or NO	Varicose veins	YES or NO	Numbness/tingling	YES or NO
Leg cramps	YES or NO	Ulcers on feet	YES or NO	Neuropathy	YES or NO
Have you taken heart or water pills?	YES or NO	<b>GASTROINTESTINAL</b>		Other:	
		Trouble swallowing	YES or NO	<b>EARS/NOSE/THROAT/MOUTH</b>	
When was your last EKG?		Nausea and vomiting	YES or NO	Ear infection	YES or NO
<b>RESPIRATORY (Lungs)</b>		Abdominal pain	YES or NO	Sore throat	YES or NO
Wheezing	YES or NO	Constipation	YES or NO	Sinus problems	YES or NO
Frequent cough	YES or NO	Diarrhea	YES or NO	Other:	
Shortness of breath	YES or NO	GI bleeding	YES or NO	<b>MUSCULOSKELETAL</b>	
Disruptive snoring	YES or NO	Special diet	YES or NO	Joint pain	YES or NO
Other:		<b>CONSTITUTIONAL SYMPTOMS</b>		Neck pain	YES or NO
<b>ENDOCRINE</b>		Fever	YES or NO	Back pain	YES or NO
Hormone problems	YES or NO	Chills	YES or NO	Foot or leg cramps	YES or NO
Thyroid disease	YES or NO	Headache	YES or NO	Artificial joints	YES or NO
Diabetes	YES or NO	Weight gain	YES or NO	Bunions	YES or NO
Osteoporosis	YES or NO	Weight loss	YES or NO	Hammertoes	YES or NO
Gout	YES or NO	Other:		Ankle pain	YES or NO
Liver disease	YES or NO	<b>EYES</b>		Heel pain	YES or NO
<b>GENITOURINARY</b>		Blurred vision	YES or NO	Flat feet	YES or NO
Urine Retention	YES or NO	Double vision	YES or NO	Other:	
Painful urination	YES or NO	Pain	YES or NO		
Kidney disease	YES or NO	Other:			
Other:					

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_