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 drinks a week?_____	How many per day?_____ How many years? _____	How often?_____ 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)	
Chest pain	YES or NO
Heart trouble	YES or NO
Heart Attack	YES or NO
Angina Pectoris	YES or NO
High cholesterol	YES or NO
High blood pressure	YES or NO
Fainting	YES or NO
Racing of heart	YES or NO
Rheumatic fever	YES or NO
Abnormal EKG	YES or NO
Swelling of Ankles	YES or NO
Leg cramps	YES or NO
Have you taken heart or water pills?	YES or NO
When was your last EKG?	
RESPIRATORY (Lungs)	
Wheezing	YES or NO
Frequent cough	YES or NO
Shortness of breath	YES or NO
Disruptive snoring	YES or NO
Other:	
ENDOCRINE	
Hormone problems	YES or NO
Thyroid disease	YES or NO
Diabetes	YES or NO
Osteoporosis	YES or NO
Gout	YES or NO
Liver disease	YES or NO
GENITOURINARY	
Urine Retention	YES or NO
Painful urination	YES or NO
Kidney disease	YES or NO
Other:	

HEMATOLOGY/LYMPHATIC	
Swollen glands	YES or NO
Blood clotting problems	YES or NO
Coumadin therapy	YES or NO
Other:	
SKIN	
Skin rash	YES or NO
Athletes foot	YES or NO
Corns/calluses	YES or NO
Ingrown nails	YES or NO
Plantar warts	YES or NO
Varicose veins	YES or NO
Ulcers on feet	YES or NO
GASTROINTESTINAL	
Trouble swallowing	YES or NO
Nausea and vomiting	YES or NO
Abdominal pain	YES or NO
Constipation	YES or NO
Diarrhea	YES or NO
GI bleeding	YES or NO
Special diet	YES or NO
CONSTITUTIONAL SYMPTOMS	
Fever	YES or NO
Chills	YES or NO
Headache	YES or NO
Weight gain	YES or NO
Weight loss	YES or NO
Other:	
EYES	
Blurred vision	YES or NO
Double vision	YES or NO
Pain	YES or NO
Other:	

ALLERGIC/IMMUNOLOGIC	
Hay fever	YES or NO
Drug allergies	YES or NO
AIDS/HIV	YES or NO
Hepatitis	YES or NO
Cancer	YES or NO
Radiation therapy	YES or NO
Other:	
NEUROLOGICAL	
Stroke	YES or NO
TIA (mini-stroke)	YES or NO
Numbness/tingling	YES or NO
Neuropathy	YES or NO
Other:	
EARS/NOSE/THROAT/MOUTH	
Ear infection	YES or NO
Sore throat	YES or NO
Sinus problems	YES or NO
Other:	
MUSCULOSKELETAL	
Joint pain	YES or NO
Neck pain	YES or NO
Back pain	YES or NO
Foot or leg cramps	YES or NO
Artificial joints	YES or NO
Bunions	YES or NO
Hammertoes	YES or NO
Ankle pain	YES or NO
Heel pain	YES or NO
Flat feet	YES or NO
Other:	

Patient's signature:_____ Date:_____