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 _____

_____