

Office Use: Ht _____ BP _____
Wt _____ Pls _____

HEALTH & HISTORY QUESTIONNAIRE

Please answer all questions completely. Information is confidential.

Name _____ Date _____

D.O.B. _____ Age _____ Referring M.D. _____ City/State _____

Reason for visit _____

Current medications _____

Medication allergies _____

Do you have pain, weakness, or difficulty moving:

Arms	Yes	No	Neck	Yes	No	Legs	Yes	No
Hands	Yes	No	Back	Yes	No	Feet	Yes	No
shoulders	Yes	No	Hips	Yes	No	Other	Yes	No

If yes, please describe _____

When did your symptoms begin and what caused them? _____

Are your symptoms: Constant Or intermittent

Are your symptoms worse at a certain time or day, or with certain activities? Yes No

If yes, please describe _____

Are your injuries due to Work Auto accident Other _____

If work-related, explain the kind of work you do _____

Do you have, or have you ever had:

<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Irregular/fast heart	<input type="checkbox"/> Polio	<input type="checkbox"/> Breathing problems
<input type="checkbox"/> Sudden weight loss	<input type="checkbox"/> Swelling in feet/legs	<input type="checkbox"/> TB	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Blurred/double vision	<input type="checkbox"/> Bloody sputum	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcers/stomach pain
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sores that won't heal	<input type="checkbox"/> Chronic tiredness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcohol/drug dependency	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> pacemaker
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Gout	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Lung disease

Family history: Has anyone in your family ever had any of the above? Yes No

If yes, please list who and what condition: _____

**PLEASE COMPLETE THE REVERSE SIDE AND SIGN
HEALTH & HISTORY QUESTIONNAIRE**

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Do you smoke or chew? Yes No How much? _____ How long? _____

Do you drink alcoholic beverages? Yes No If yes, how much/often? _____

Your surgical history: _____

****If you are being seen for your feet or ankles, please fill out the questions below; if not skip down to the bottom to sign your name****

Have you had foot surgery? Yes No If so, when was it done? _____

What foot surgery was done? _____

What other types of treatment have you tried for your feet? _____

What helps your condition? _____

What makes it worse? _____

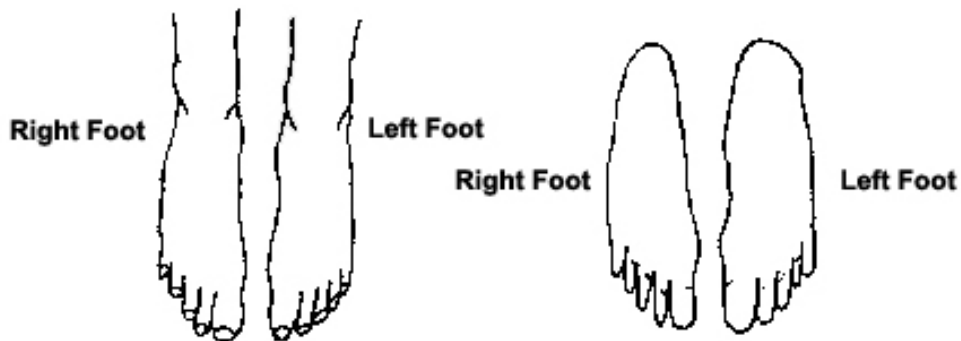
Since the problem has began, has it ___ Worsened? ___ Improved? ___ Stayed the same?

Does the type of shoe you wear make a difference? Yes No

What is your occupation? _____

Foot Diagram

Shade in the area of your problem. Number the area on a scale of 1 – 10 according to pain, with 1 being mild, occasional pain and 10 being worst pain imaginable.



I certify that the above information is true and correct, to the best of my knowledge. I will not hold my doctor or members of his/her staff responsible for any omissions I made in completing this form.

Signature: _____

Date: _____