FAMILY Podiatry and Vein Care

Medical & Surgical Foot Specialist
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HEALTH HISTORY QUESTIONNAIRE

Date _____

Name _____ Birth Date _____

Height _____ ft. _____ in. Weight _____ lbs.

CHIEF COMPLAINT AND HISTORY: Please describe for what we are seeing you for.

_____

_____

APPX. WHEN DID THIS CONDITION BEGIN? _____

HAVE YOU PREVIOUSLY SEEN A PODIATRIST? **[ ] YES [ ] NO**

IF SO, WHEN AND FOR WHAT? _____

PAST MEDICAL HISTORY: List any medical conditions you may have

_____

_____

PAST SURGICAL HISTORY: List any surgeries you may have had _____

_____

CURRENT MEDICATIONS:

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4. _____ **8.** _____

Additional Meds: _____

CURRENT ALLERGIES: Please check all that apply.

[ ] Penicillin [ ] Novocaine [ ] Sulfa [ ] Iodine [ ] Aspirin [ ] None

[ ] Other-Please List: _____

[ ] No Active Allergies

SOCIAL HISTORY:

[ ] **Tobacco**: packs per day _____ How many years? _____ When did you quit? _____

[ ] **Tobacco**: **Electronic Vaporizers**: How Often per day? _____ When did you quit? _____

[ ] **Non-Tobacco/Electronic Vaporizer User**

[ ] **Alcohol**: How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (Ex: None or response ≥ 1) _____

[ ] **Non-Alcohol User**

Job Description: [ ] Mostly standing [ ] Mostly sitting [ ] Mix of both [ ] Retired

I hereby give Dr. Scott Koppel permission to examine and treat me.

Patient, Parent, or Guardian's Signature _____