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 ____