ARCHES
Foot and Ankle Clinic

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Referring doctor:	**Preferred Pharmacy:**	
If you are female, is there a possibility you are pregnant?	☐ Yes ☐ No	
Reason for your visit today:		
When did the problem begin:		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations: ☐ Influenza Vaccine (current) ☐ Pneumococcal Vaccine (current)

Circle any medical problems that other doctors have diagnosed

Anemia
Anxiety disorder
Arthritis
Asthma
Bleeding disorder
Blood clots
Back problems
Cancer
Congestive Heart Failure
COPD

Coronary Artery Disease
Deep Vein Thrombosis
Dementia
Depression
Diabetes
Epilepsy
Reflux/GERD
Gout
HIV/AIDS
Headaches

Heart attack
Heart disease
Heart problems
Hepatitis
High Cholesterol
Hypertension
Kidney disease
Leg/foot ulcers
Liver disease
Osteoporosis

Pneumonia
Peripheral neuropathy
Peripheral vascular disease
Pulmonary embolism
Rheumatoid arthritis
Seizure
Stroke
Thyroid disease
Ulcers/stomach

Other:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had
Other Allergies	

HEALTH HABITS AND PERSONAL SAFETY

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Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	☐Beer ☐Wine ☐Hard Alcohol	What best describes your drinking: social ☐ occasional ☐ Light ☐ heavy ☐			
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Dipping – #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit			
Drugs	Have you ever used any illegal or street drugs?	☐Never Used ☐Current User ☐Previous User			

FAMILY HEALTH HISTORY

ARE YOU ADOPTED? ☐ YES ☐ NO

ONLY SIGNIFICANT HEALTH PROBLEMS					
FAMILY MEMBER		**LIST HEALTH PROBLEM:**	**FAMILY MEMBER**		**LIST HEALTH PROBLEM:**
Father	☐ Alive ☐Deceased		**Children**	☐ M ☐ F	
Mother	☐ Alive ☐Deceased			☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandmother** *Paternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandfather** *Maternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandfather** *Paternal*	☐ Alive ☐ Deceased	

Patient/Guardian Signature:________________________________ Date:______________________