

HEALTH QUESTIONNAIRE

(If you have any questions about the information we are requesting, please ask.) **PLEASE PRINT CLEARLY**

LAST NAME _____	FIRST _____	MI _____
HEIGHT _____	WEIGHT _____	SHOE SIZE _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER (____) _____ - _____

CITY _____ DATE OF LAST VISIT _____

HAVE YOU SEEN A PHYSICIAN ANYTIME IN THE LAST 2 YEARS? YES NO IF YES, FOR WHAT REASON?

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS? YES NO IF YES,

WHEN _____ WHERE _____ WHY _____

SURGICAL HISTORY (List Most Recent and Approximate year) _____

*** DOES ANYONE IN YOUR IMMEDIATE FAMILY SUFFER FROM DIABETES? If yes, whom?

MEDICATIONS CURRENTLY TAKING: (IF YOU HAVE A MEDICATION LIST PLEASE GIVE COPY TO FRONT OFFICE)

TYPE:

- Blood Thinner
- Diabetes
- Birth Control
- Diuretic (Water Pill)
- Blood Pressure
- Ulcer
- Antibiotic
- Arthritic
- Nerves
- Other

PRESCRIPTION:

UNUSUAL or ALLERGIC REACTION to any of the following (nausea, rash, rapid heartbeat, etc.): (PLEASE CHECK)

- | | |
|---|--|
| <input type="radio"/> PENICILLIN- _____ | <input type="radio"/> IODINE- _____ |
| <input type="radio"/> SULFA- _____ | <input type="radio"/> TETANUS- _____ |
| <input type="radio"/> OTHER ANTIBIOTICS- _____ | <input type="radio"/> CODEINE- _____ |
| <input type="radio"/> LOCAL ANESTHETICS- _____ | <input type="radio"/> DEMEROL- _____ |
| <input type="radio"/> ADHESIVE TAPE- _____ | <input type="radio"/> LATEX- _____ |
| <input type="radio"/> BARBITUATES OR SEDATIVES- _____ | <input type="radio"/> ANTI-INFLAMMATORY- _____ |
| <input type="radio"/> SLEEPING PILLS- _____ | <input type="radio"/> OTHER- _____ |

MEDICAL HISTORY - PLEASE CHECK IF YOU EVER HAD OR CURRENTLY SUFFER FROM:

- | | | |
|---|--|--|
| <input type="radio"/> Diabetes | <input type="radio"/> Lung Disease | <input type="radio"/> Varicose Veins |
| <input type="radio"/> Heart Ailment | <input type="radio"/> Tumors or Cancer | <input type="radio"/> Ulcer/Colitis |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Arthritis | <input type="radio"/> Injury- Feet, Ankles, Legs or Back |
| <input type="radio"/> Circulatory Disorders | <input type="radio"/> Epilepsy | <input type="radio"/> Liver Disease |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Gout | <input type="radio"/> Kidney/Bladder Disease |
| <input type="radio"/> Stroke | <input type="radio"/> Phlebitis | <input type="radio"/> Venereal Disease |

FAMILY and SOCIAL HISTORY:

- 1. Are you, to the best of your knowledge, pregnant at this time? Yes No
- 2. Have you gained/lost weight recently (more than 20 lbs.)? Yes No
- 3. Is there a family history of diabetes? Yes No
- 4. Is there a family history of gout? Yes No
- 5. Is there a family history of arthritis? Yes No
- 6. Is there a family history of bunions or other foot disorders? Yes No
- 7. Are you excessively nervous on a regular basis? Yes No
- 8. Do you have a tendency to get dizzy or faint? Yes No
- 9. Do you bruise easily? Yes No
- 10. Do you bleed for a long time when you cut yourself? Yes No
- 11. Do you form thick or excessive scars? Yes No
If yes, where: _____
- 12. Do you now or have you ever smoked? Yes No
a. No. of packs per day: _____
b. How long since you quit? _____ Yes No
- 13. Do you drink alcohol? Yes No how often? Occasionally Socially Frequently

LEG and FOOT HISTORY:

- Do you limit your activities because your feet hurt? Yes No - Sports activities Daily activities
- Do your feet or ankles swell regularly? Yes No - Are you taking water pills? Yes No
- Do you have cramping in your legs or feet? Yes No - when does this occur? A.M. P.M.
- Does your job require a lot of walking or standing? Yes No
- What type of shoes do you wear? _____
- Do you now have or have you ever worn foot inlays? Yes No
If yes, are they custom made? Yes No
- Have you ever had long-term steroid therapy? Yes No If yes, for how long? _____
- Have you ever had any previous foot treatment? Yes No
Any Foot or ankle surgery? Yes No
- If yes, by whom? _____ What was done and when _____

BRIEFLY DESCRIBE YOUR FOOT PROBLEM (including where the pain/problem is located): _____

How much pain are you experiencing? MILD MODERATE SEVERE

Are there any other medical and/or mental problems? Yes No
If yes, please explain: _____

Your signature signifies you have answered this questionnaire to the best of your knowledge. Please inform the office staff and/or Dr. Davey Suh if there are any significant changes in your health.

Signature: _____ Date: _____
Patient and/or Legal Guardian

UPDATED _____
UPDATED _____
UPDATED _____ (Staff: Please initial and date when patient updates this form)

THANK YOU!