

**Podiatry Center
Health Questionnaire**

Patient Name _____ Date _____

How can we help you with your foot/ankle today?

What treatment have you received before your visit today?

Do you now or have you had:

Diabetes	Yes	No	Liver Disease	Yes	No
Heart Disease	Yes	No	Kidney Disease	Yes	No
Stroke	Yes	No	High Blood Pressure	Yes	No
Rheumatic Fever	Yes	No	Artificial Joint	Yes	No

Have you ever smoked/used tobacco products? _____ If so, how much/often? _____

Height _____ ft _____ in Weight _____

Do you have any other serious illness?

Have you been hospitalized over night in the last five years, and for what reason?

What medications are you currently taking?

Please list any medications you are allergic to:

Please list any complications from previous surgeries:

Who is your family physician and when was your last visit?
