

**Podiatry Center
Health Questionnaire**

Patient Name _____ Date _____

What is the nature of your foot complaint?

What Treatment have you received for the complaint?

Do you now have, 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

Do you have any other serious illness?

Have you been hospitalized 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?
