



**Podiatry Center  
Health Questionnaire**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**What is the nature of your foot complaint?**

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**What Treatment have you received for the complaint?**

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**Do you now have, or have you had:**

<b>Diabetes</b>	<b>Yes</b>	<b>No</b>	<b>Liver Disease</b>	<b>Yes</b>	<b>No</b>
<b>Heart Disease</b>	<b>Yes</b>	<b>No</b>	<b>Kidney Disease</b>	<b>Yes</b>	<b>No</b>
<b>Stroke</b>	<b>Yes</b>	<b>No</b>	<b>High Blood Pressure</b>	<b>Yes</b>	<b>No</b>
<b>Rheumatic Fever</b>	<b>Yes</b>	<b>No</b>	<b>Artificial Joint</b>	<b>Yes</b>	<b>No</b>

**Do you have any other serious illness?**

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

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**What medications are you currently taking?**

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**Please list any medications you are allergic to:**

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**Please list any complications from previous surgeries?**

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

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