ADVANCED FOOT & ANKLE CENTER

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Patient Name:_____ Weight:_____ Height:_____ Shoe Size:_____

HEALTH QUESTIONNAIRE

1.) **Do you have any allergies to drugs or foods?** If yes, please list _____ YES NO
_____

2.) **Do you have hay fever or asthma?** YES NO

3.) **Are you currently taking any medications**? YES NO
*** *Please list all medications on attached sheet*

4.) **Do you have a family physician or a private physician** YES NO
Please list name & address:_____

5.) **Please circle any of the following illnesses which you have and/or had**:
Heart disease (murmur, heart failure, arrhythmia, heart attack), hypertension (high blood pressure), Asthma, rheumatic fever, emphysema, tuberculosis, pneumonia, diabetes, stomach ulcer, hepatitis, Jaundice, anemia stroke, seizures (convulsions), phlebitis (blood clots in veins), recurrent infections (bladder, prostate, kidney, sinus, respiratory), tumor or growth

6.) **Have you had any previous surgery**? YES NO
Please list all surgeries:_____

7.) **Have you had any problems with anesthesia**? YES NO

8.) **Have you have any problems with abnormally easy bleeding**? YES NO

9.) **Have you had any major traumas (fractures, etc.)**? YES NO

10.) **Have you been hospitalized over the past two years**? YES NO

11.) **Do you have any known contagious diseases**? YES NO

12.) **Have you been treated for exposure to the AIDS virus**? YES NO

13.) **Women**: **Are you pregnant or think you may be pregnant**? YES NO

14.) **Habits: Do you smoke**? YES NO
Number of packs per day:_____ Number of years:_____

15.) **Do you use alcohol**? YES NO
If so, which type: Beer Wine Hard Liquor How much per week?_____

Please provide other health information you deem important:

_____

_____

SIGNATURE: _____ DATE: _____