

PODIATRIC MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Home Phone: _____
 Address: _____ Work Phone: _____
 City: _____ State: _____ Zip: _____ Cell Phone: _____
 Birth Date: ___/___/___ Social Security (opt): _____ e-mail: _____
 Age ___ Sex ___ Ht ___ Wt ___ Shoe size _____
 Occupation: _____ Last Medical Exam: _____
 Primary Care Physician: _____ Previous Foot Physician: _____
 PCP Address: _____ Last Foot Exam: _____
 Who may we thank for referring you? _____

1) INSURANCE INFORMATION

Do you have Insurance? Yes No Primary Insurance Company _____
 Insurance Policy Holder's Name _____ Relationship to patient _____ DOB _____
 Insured SSN _____ Insured's Employer _____
 Secondary Insurance Company _____

Was the HIPPA – Notice of Privacy Practices form made available to you? _____ (Please initial)

2) CHIEF FOOT COMPLAINT

What is your main Foot Problem today? _____

Do you have any other Foot problems that need attention? _____

3) HISTORY OF PRESENT ILLNESS

When did the problem begin? _____ Where is the area of the problem? _____

Was it caused by an injury? No Yes _____

Any Previous treatment? No if Yes, what have you tried? _____

Rate the your pain from 1 to 10 (ten being excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

4) PAST MEDICAL HISTORY

Do you have any of the following medical conditions?

Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back / Spine pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV / AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulation Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>	Leg Cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy/Seizure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swelling of limbs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>

Other Yes No (list) _____

Which of the above illnesses are in your immediate family? _____

List ANY medications you take prescription or over the counter: _____

Do you have any allergies to medication? (if so, list) _____

List ALL major injuries, surgeries and hospitalizations: _____

Are you pregnant or nursing? (if applicable) Yes No

5) SOCIAL HISTORY

Marital status / Living arrangement Single Married Other _____

Do you use tobacco products? Yes No If yes, what type/ amount/ how long? _____

Do you use illegal drugs Yes No If yes, what type/ amount/ how long? _____

Do you drink alcohol? Yes No If yes, what / how much / how often? _____

Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? Yes No

Hobbies & Activities? _____

6) REVIEW OF SYSTEMS

Do you currently have or chronically suffer from any of the following conditions?

INTEGUMENTARY (Skin)

- | | | |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Deformed nails | <input type="checkbox"/> Itching | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Discolorations | <input type="checkbox"/> Skin Cancers | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Eczema / Psoriasis | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Other _____ |

HEMATOLOGIC (blood)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Take aspirin | <input type="checkbox"/> Take coumadin |
|--|---------------------------------------|--|

NERVOUS

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Muscle jerking | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Numbness / Burning | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Other _____ |

MUSCULOSKELETAL

- | | | |
|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sprains | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Other _____ |

Are you aware that we have screening for Vascular Disease, Neuropathy, & Osteoporosis available at this office?

Are you aware that we have advanced screening for Eye and Retinal diseases available at the office?

I hereby give Head to Toe Healthcare, PLC permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered and, if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I also authorize payment of medical benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill.

****As a Courtesy, we will bill your insurance company for you****

X _____ Signature Date: _____