Foot & Ankle CENTER OF ILLINOIS

2921 Montvale Drive
Springfield, IL 62704

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):* ☐ M ☐ F			**Acct #:**
Date of Birth:	**Age:**	**SSN:**	**Date:**
Address:		**Email:**	
Height:	**Weight:**	**Blood Pressure:**	**BMI:**

Race: ☐ White ☐ More than one race ☐ Native Hawaiian ☐ Not Reported ☐ Other Pacific Islander ☐ Unknown ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined

Ethnicity: ☐ Declined ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Not Reported ☐ Unknown

Language: ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other

Phone #: Work: Home: Cell:

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children: Y / N Ages:	**Living Situation: Home, Nursing Home, Other:**
Family/Primary Care Doctor:	**Occupation:**
Doctor who referred you to FACI:	**Name of your employer:**
Preferred Pharmacy:	**Is this a work-related injury?** ☐ Yes ☐ No

Reason for today's visit:

PERSONAL HEALTH HISTORY

Current/Chronic Medical Problems (e.g., diabetes, hypertension, high cholesterol)

Illness	Illness

Past Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Drug Name	Drug Name

Allergies to medications

Drug Name	Reaction You Had

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Patient Name: _____ Acct #: _____

OTHER PROBLEMS

Check if you or a member of your immediate family have, or have had, any of the following problems.

You:	Family:		You:	Family:	
☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Heart Attack	☐	☐	COPD
☐	☐	Stroke	☐	☐	Emphysema
☐	☐	Seizure	☐	☐	HIV/AIDS
☐	☐	Heart Disease	☐	☐	Hepatitis (Type: _____)
☐	☐	Pacemaker ID# _____ Company Phone # _____	☐	☐	Do you take blood thinners? Aspirin _____ Coumadin _____ Plavix _____
☐	☐	Depression	☐	☐	Liver Disease
☐	☐	Anxiety	☐	☐	Ulcer
☐	☐	Kidney Disease	☐	☐	GERD
☐	☐	Thyroid Disease	☐	☐	Anemia
☐	☐	Diabetes (Type: _____)	☐	☐	Clotting problem/DVT/Pulmonary Embolus
☐	☐	Cancer (Type: _____)	☐	☐	Neuropathy
☐	☐	History of MRSA or have had an infection that required isolation			
☐	☐	Other:			

HEALTH HABITS AND PERSONAL SAFETY

Tobacco	Do you use tobacco? How much?	☐ Yes # of years:	☐ No Or, year quit:
Imaging	Have you had X-rays, MRI or CT for this problem?	☐ Yes If yes, where?	☐ No
Pregnancy	Are you pregnant?	☐ Yes	☐ No
Latex	Are you allergic to latex?	☐ Yes	☐ No
Ambulatory Aids	Do you use ambulatory aids? If so, what? Crutches Walker Cane Other:_____	☐ Yes	☐ No
Alcohol	Do you drink alcohol? If yes, what kind? How many drinks per week?	☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No

OFFICE USE ONLY

I certify that I have reviewed the above information. DPM