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Medical Health Questionnaire

Salt Lake Podiatry Center
Foot & Ankle Specialists

Date:_____ Date of birth:_____

Patient Name _____Age:_____ Male □ Female □ Height:___ ft ___in Weight:____ lbs
Please describe your problem: (Where, When, What aggravates it, How long has it hurt, Describe the pain, Cause?)

_____

_____

_____

What treatments have you received for this problem(s)?

_____

_____

Do you now or have you ever had:

Diabetes	Yes	No	Liver Disease	Yes	No	Lung Disease	Yes	No
Heart Disease	Yes	No	Kidney Disease	Yes	No	Arthritis	Yes	No
Stroke	Yes	No	High Blood Pressure	Yes	No	Substance Abuse	Yes	No
Rheumatic Fever	Yes	No	Artificial Joints	Yes	No	Chronic Pain	Yes	No
Weight Loss	Yes	No	Cancer	Yes	No	Foot/Leg Wounds	Yes	No
Vascular Disease	Yes	No	Skin Disease	Yes	No	Foot Deformities	Yes	No

Tobacco Use: Never □ Current Packs/day: _____ Former (date quit): _____ Previous Packs/Day _____
Alcohol Use: Never □ Current amount/week: _____ Former (date quit): _____

What illnesses do you have?_____

_____

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

_____

_____

What medications are you currently taking?

_____

_____

Please list any medications / substances you are **ALLERGIC** to:

_____

Please list any complications from previous surgeries including reactions to anesthesia or pain medications:

_____

Who is your family physician and when was your last visit? Where is your doctor located?

_____

How did you find out about our office (friend, family, internet, doctor, billboard, other...)?

_____