Tri-Valley
MEDICAL CENTER, INC.

HEALTH HISTORY QUESTIONNAIRE - PODIATRY

Welcome to our office. All the following questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your knowledge. These questions will assist us in your comprehensive and efficient medical care. All questions contained in this questionnaire are optional and will be kept strictly confidential.

Name *(Last, First, M.I.)*: ☐M ☐F	**Date of Birth:**
Marital status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed	
Race/Ethnicity: ☐Declined to specify ☐Caucasian ☐Asian ☐Middle Eastern ☐Hispanic ☐African-American ☐Other:	
Previous or referring physician: *please include name, address, & phone number*	

CURRENT MEDICAL CONDITIONS *(circle all that apply)*		
AID/HIV	Coronary Artery Disease	Osteoporosis
Anemia	Depression	Prostate Problems
Anxiety	Diabetes	Renal Disease
Arthritis	Drug Dependency	Seasonal Allergies
Asthma	Fibromyalgia	Seizure Disorder
Atrial Fibrillation	Gout	Sleep Apnea
Bleeding Disorder	GERD	Thyroid Disease
Cancer *(please specify)*:	Hepatitis C	Other Illnesses:
	Hyperlipidemia/High Cholesterol	
Cerebrovascular Accident/Stroke	Hypertension/High Blood Pressure	
Congestive Heart Failure	Kidney Disease	
COPD	Multiple Sclerosis	

PODIATRIC HISTORY *(circle any current and previous conditions)*		
Heel pain/arch pain	Painful corns	Shooting pain in feet and lower legs
Bunion pain	Warts	Inability to sleep due to foot pain
Flat Feet	Rashes/Itching	New exercise(s)
Numbness or tingling in feet	Hammertoes – curled toes	Other pain or discomfort:
Trauma or injury (please specify):	Circulation issues	
	Recent changes in weight (please specify):	

CURRENT MEDICATIONS: *Please list prescribed & over-the-counter drugs being taken*

Name & Dosage	Frequency Taken	Name & Dosage	Frequency Taken

Tri-Valley
MEDICAL CENTER, INC.

ALLERGIES: *Please list food and drug allergies* ☐ **No known allergies**	
Name & Reaction	Name & Reaction

SURGERIES & OTHER HOSPITALIZATIONS			
Year	Reason	Hospital	Outcome

CHILDHOOD ILLNESSES: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox/Varicella ☐Polio

DIAGNOSTIC STUDIES *(please include dates)*	
☐X-Rays:	☐Arterial Doppler Ultrasound:
☐Bone Density Scan:	☐Other:

IMMUNIZATIONS *(please include date given)*	
☐ Tetanus (Tdap/Td)	☐Other:

HEALTH HABITS AND PERSONAL SAFETY		
Caffeine	☐None ☐Coffee ☐Tea ☐Cola	# Of cups/cans per day:
Alcohol	Do you drink alcohol?	☐Current ☐Former ☐Never
	If yes, what kind?	☐Beer ☐Wine ☐Hard Liquor ☐Gin ☐Whiskey ☐Other:
	How many drinks per week?	
Tobacco	Do you use tobacco?	☐Current ☐Former ☐Never
	☐Cigarettes – pks./day:	☐Chew - #/day: ☐Pipe - #/day: ☐Cigars - #/day:
	# of years used:	Or year quit:
Sex	Are you sexually active?	☐Yes ☐No
	If yes, are you trying for a pregnancy? ☐Yes ☐No	

FAMILY HEALTH HISTORY ☐ Adopted			
	SIGNIFICANT HEALTH PROBLEMS		SIGNIFICANT HEALTH PROBLEMS
Father	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	**Children**	☐M/☐F
			☐M/☐F
Mother	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:		☐M/☐F
			☐M/☐F
Sibling(s)	☐M/☐F	**Significant relative(s):**	
	☐M/☐F		