



Regional
FOOT & ANKLE

Patient History Questionnaire

Patient Name _____ Date of Birth _____

Patient's SSN _____ - _____ - _____ Patient's Shoe Size _____

If you would like electronic access to your medical records, please list a current email and you will be signed up for CMH portal. (your email will not be shared)

Email _____

Have you ever had any of the following conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Degenerative Disc Dx |
| <input type="checkbox"/> Transfusion Reactions | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Respiratory Disorders | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> VRE | <input type="checkbox"/> GERD | <input type="checkbox"/> Diabetic Ketoacidosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other GI Disorders | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Endocrine Disorders |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Depression |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Genitourinary Disorder | <input type="checkbox"/> Behavior Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> STD'S | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pelvic Inflammatory Dx | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Pregnancy Complication | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Hypertension (High BP) | <input type="checkbox"/> Preterm | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Cardiac Disorders | <input type="checkbox"/> Reproductive Disorders | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Throat Problems |

Other Not Listed?

- | | | |
|---|--|--|
| <input type="checkbox"/> Past Smoker | <input type="checkbox"/> Do you want help to quit? | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Current Smoker | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Wear glasses/contacts |

Guarantor Information

Guarantor's Name

Guarantor's SSN

Guarantor's Address
(if different from patient's)

Guarantor's Phone
(if different from patient's)
