



Regional  
FOOT & ANKLE

# Patient History Questionnaire

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Patient's Shoe Size \_\_\_\_\_

## 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?

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- |   |  |  |
|---|--|--|
| <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

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Guarantor's SSN

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

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

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