**Podiatry Health History**

Name: ____________________________________________________ Date of Birth: ____________________

Family Doctor: ___________________________________ Last Visit: ________________________________

Have you ever seen Dr. Ingrid Stines at another facility? ☐ Yes ☐ No

If "yes," which facility? ___________________________________________________

If "no," how did you hear of us?

☐ Website ☐ Facebook ☐ Family Member ☐ Another Patient ☐ Referred by: ____________________

My foot problem is: __________________________________________________________________________

When did problem start & how has it been treated? _________________________________________________

Any other foot problems in the past? ☐ Yes ☐ No If "yes," Explain: ______________________________________

Preferred Pharmacy: __________________________________________________________________________

Do you currently have or have had any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Diabetes Type 1 | Yes | No | Diabetes Type 2 | Yes | No | High Blood Pressure | Yes | No |
| Peripheral Vascular Disease | Yes | No | Tumors | Yes | No | Nervousness | Yes | No |
| Leg Cramps | Yes | No | Gout | Yes | No | Arteriosclerosis | Yes | No |
| Cancer | Yes | No | Glaucoma | Yes | No | Venereal Disease | Yes | No |
| Hepatitis | Yes | No | Epilepsy | Yes | No | Rheumatic Fever | Yes | No |
| Varicose Veins | Yes | No | Asthma | Yes | No | Rheumatism/Arthritis | Yes | No |
| Infections | Yes | No | Stomach Ulcers | Yes | No | HIV/Aids | Yes | No |
| Fractures | Yes | No | Kidney Trouble | Yes | No | Bleeding Tendencies | Yes | No |
| Polio | Yes | No | Stroke | Yes | No | Tuberculosis | Yes | No |
| Anemia | Yes | No | Heart Trouble | Yes | No | Are you Pregnant? | Yes | No |

If "yes" to any of the above, Explain:

______________________________________________________________________________________________

______________________________________________________________________________________________

Marital Status:______________________________ Who do you live with?___________________________

How many children do you have?_________________ Special Diet: ________________________________

Employment: ☐ Employed ☐ Not Employed ☐Retired Occupation (current or former): ____________________

What is your general health condition? _______________ Do you exercise? ____________________________

Is there any family history of Diabetes? ☐ Yes ☐ No If "yes," relationship: _____________________________

Do you consume alcohol? ☐ Yes ☐No If "yes," how much per week: __________________________________

Do you smoke tobacco products (currently or formerly)? ☐ Yes ☐ No

If "yes," how much/often: ________________________________

Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No

If "yes," Explain: _______________________________________________________________________

**Please complete the back side of this form.** ⇨

Please list all previous operations and dates:

| Surgery: | Date: | Surgery: | Date: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you allergic to any of the following? If "yes" to any allergies, what was the reaction?

| Allergy: | Yes | No | Reaction: | Allergy: | Yes | No | Reaction: |
|---|---|---|---|---|---|---|---|
| Adhesives/Tapes | | | | Merthiolate | | | |
| Aspirin | | | | Novacaine | | | |
| Antihistamines | | | | Nylon, Plastics | | | |
| Codeine | | | | Penicillin | | | |
| Demerol | | | | Sulfa | | | |
| Iodine | | | | Sutures | | | |
| Mercurials | | | | Sulfides | | | |
| Bees | | | | Other: | | | |

List medications and dosages you are currently taking (Please include dosage amount and how often).

| Medication: | Dosage and Amount: | How often do you take it? |
|---|---|---|
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
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| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |
| | | ☐ 1x/day ☐2x/day ☐3x/day ☐Other: ____________________ |

Is there anything else about your health that we should know?
__________________________________________________________________________________________
__________________________________________________________________________________________

**Date:** ______________________ **Completed by:** __________________________________________________

**Signature:** ____________________________________________________________________________