

## PERSONAL HEALTH HISTORY

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

How would you rate your overall health? (CIRCLE)    Excellent    Good    Fair    Poor

● PLEASE CHECK THE APPROPRIATE PLACES. I have or have had the following:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Leg Cramps          | <input type="checkbox"/> Venereal Disease       | <input type="checkbox"/> AIDS / HIV Positive |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Nervous Disorders      | <input type="checkbox"/> Sickle Cell Trait   |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Eye Trouble            | <input type="checkbox"/> Lung Problems       |
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Back Trouble        | <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Bladder Infections  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Varicose Veins      | <input type="checkbox"/> Gout                | <input type="checkbox"/> Keloid Formation       | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Menopause           |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> Seasonal Allergies     | <input type="checkbox"/> Numbness in Feet    |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Polio               | <input type="checkbox"/> Swollen Feet or Ankles | <input type="checkbox"/> Skin Diseases       |
| OTHERS: _____                                |  |   |  |

● ARE YOU ALLERGIC OR SENSITIVE TO ANY OF THE FOLLOWING:

- |                                     |   |  |   |
|-------------------------------------|---|--|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine or Morphine          | <input type="checkbox"/> Adhesive Tape     |   |
| <input type="checkbox"/> Sulfa      | <input type="checkbox"/> Merthiolate or Mercurochrome | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Tetanus Serum                | <input type="checkbox"/> Iodine            |   |
| <input type="checkbox"/> Cortisone  | <input type="checkbox"/> Other Antibiotics            | Any others _____                           |   |

● DO YOU TAKE ANY OF THE FOLLOWING: (PLEASE CIRCLE)

- |                         |  |                       |  |
|-------------------------|--|-----------------------|--|
| <u>Alcohol</u>          | Never    Occasionally    Frequently    Daily | <u>Sedatives</u>      | Never    Occasionally    Frequently    Daily |
| <u>Aspirin, Tylenol</u> | Never    Occasionally    Frequently    Daily | <u>Sleeping Pills</u> | Never    Occasionally    Frequently    Daily |
| <u>Coffee, Tea</u>      | Never    Occasionally    Frequently    Daily | <u>Thyroid</u>        | Never    Occasionally    Frequently    Daily |
| <u>Cortisone</u>        | Never    Occasionally    Frequently    Daily | <u>Tobacco</u>        | Never    Occasionally    Frequently    Daily |
| <u>Laxatives</u>        | Never    Occasionally    Frequently    Daily | <u>Tranquilizers</u>  | Never    Occasionally    Frequently    Daily |

● LIST THE MEDICINES YOU ARE TAKING:

Name	Dose	How Many Times a Day?	For What?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

● HAVE YOU EVER BEEN HOSPITALIZED?    YES    NO

Reason	Dates	Name of Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I HAVE READ AND UNDERSTOOD THE QUESTIONS HEREIN, AND HAVE ACCURATELY ANSWERED THEM TO THE BEST OF MY KNOWLEDGE AND ABILITY. I HEREBY GIVE THE HETTINGER PODIATRY CENTER AND ITS STAFF PERMISSION TO ADMINISTER TREATMENT AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION, BASED UPON THIS INFORMATION.

Date \_\_\_\_\_ Signed \_\_\_\_\_

(Parent or Guardian if Patient is a Minor)