PERSONAL HEALTH HISTORY

Height_____ Weight _____ Age _____ Shoe Size _____

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

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

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

_____ OTHERS:_____

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

_____ Penicillin	_____ Codeine or Morphine	_____ Adhesive Tape	
_____ Sulfa	_____ Merthiolate or Mercurochrome	_____ Local Anesthetics	_____ No Known Allergies
_____ Aspirin	_____ Tetanus Serum	_____ Iodine	
_____ Cortisone	_____ Other Antibiotics	Any others_____	

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

Alcohol	Never Occasionally Frequently Daily	Anti-Anxiety	Never Occasionally Frequently Daily
Aspirin, Tylenol	Never Occasionally Frequently Daily	Sleeping Pills	Never Occasionally Frequently Daily
Coffee, Tea	Never Occasionally Frequently Daily	Thyroid	Never Occasionally Frequently Daily
Cortisone	Never Occasionally Frequently Daily	Tobacco	Never Occasionally Frequently Daily
Laxatives	Never Occasionally Frequently Daily	Blood Thinners	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)