PREMIER FOOT & ANKLE
HEALTH HISTORY FORM

PATIENT NAME:_____ AGE:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

EMAIL ADDRESS:_____

PLEASE INDICATE BY CIRCLING YES OR NO FOR CONDITIONS PAST AND PRESENT:

ALLERGIES OR HIVES	YES NO	ANEMIA	YES NO	ANGINA	YES NO
ARTHRITIS	YES NO	ARTIFICIAL HEART VALVE	YES NO	ARTIFICIAL JOINTS	YES NO
ASTHMA	YES NO	BLEEDING DISORDER	YES NO	BLOOD DISORDERS	YES NO
CANCER	YES NO	COPD	YES NO	DIABETES	YES NO
EMPHYSEMA	YES NO	EPILEPSY	YES NO	GOUT	YES NO
HEART ATTACK/DISEASE	YES NO	PACEMAKER	YES NO	HEART SURGERY	YES NO
HEPATITIS	YES NO	HIGH BLOOD PRESSURE	YES NO	HIGH CHOLESTEROL	YES NO
HIV/AID	YES NO	KIDNEY DISEASE	YES NO	ULCERS	YES NO
LIVER DISEASE	YES NO	MUSCLE PROBLEMS	YES NO	PHLEBITIS	YES NO
EARS, NOSE, MOUTH	YES NO	PSYCHIATRIC TREATMENT	YES NO	RHEUMATIC FEVER	YES NO
SKIN DISEASE	YES NO	STENT IN HEART	YES NO	STOMACH ULCER	YES NO
STROKE	YES NO	TUBERCULOSIS	YES NO	URINARY PROBLEMS	YES NO

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICATION: DOSE: TIMES PER DAY:

_____

_____

_____

ALLERGIES AND REACTIONS:

_____

_____

HEIGHT: _____ WEIGHT:_____ ARE YOU PREGNANT? YES NO

PAST SURGERIES:

_____

_____

DO YOU SMOKE?: YES NO NEVER DAILY_____ OCCASIONAL_____ PACKS PER DAY_____

DO YOU DRINK ALCOHOL?: YES NO NEVER 1-2 WEEK_____ 1-2 DAY_____ SOCIAL_____

DO YOU HAVE A FAMILY HISTORY OF: HEART DISEASE DIABETES HYPERTENSION CANCER

PATIENT SIGNATURE_____ DATE_____