Original Date: _____/_____/_____
Dates Revised: _____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Ernest L. Isaacson, D.P.M.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: ☐ **M** ☐ **F**
(Last, First, M.I.)
DOB _____/_____/_____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or Referring Doctor:
Date of Last Physical Exam: ___

PERSONAL HEALTH HISTORY

What is your chief complaint today? _____

List any past foot or ankle problems: _____ _____
_____ _____
_____ _____

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ..... ☐ Yes ☐ No

Please turn to next page

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting?.....☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? .....☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? .....☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? .....☐ Yes ☐ No
Have you considered stopping? .....☐ Yes ☐ No
Have you ever experienced blackouts? .....☐ Yes ☐ No
Are you prone to "binge" drinking? .....☐ Yes ☐ No
Do you drive after drinking? .....☐ Yes ☐ No

Tobacco:
Do you use tobacco? .....☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:
Do you currently use recreational or street drugs? .....☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? .....☐ Yes ☐ No