Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care

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PODIATRIC MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Home Phone:**_____
Address:_____ **Work Phone:**_____
City:_____ **State:**_____ **Zip:**_____ **Cell Phone:**_____
Birth Date:____/____/____ **Social Security (opt):**_____ **e-mail:**_____
Age_____ **Sex** _____ **Ht** _____ **Wt**_____ **Shoe size** _____
Occupation:_____
Primary Care Physician:_____ **Last Medical Exam:**_____
Previous Foot Physician:_____ **Last Foot Exam:**_____
Who may we thank for referring you?_____

1) INSURANCE INFORMATION

Do you have Insurance? Yes☐ No☐ Primary Insurance Company _____
Insurance Policy Holder's Name_____ **Relationship to patient**_____ **DOB**_____
Insured SSN_____ **Insured's Employer**_____
Secondary Insurance Company _____

☐ **Was the HIPAA – Notice of Privacy Practices form made available to you?**_____**(Please initial)**

2) CHIEF FOOT COMPLAINT

What is your main Foot Problem today?_____

Do you have any other Foot problems that need attention?_____

3) HISTORY OF PRESENT ILLNESS

When did the problem begin?_____ **Where is the area of the problem?**_____

Was it caused by an injury? ☐ No ☐ Yes_____

Any Previous treatment? ☐ No ☐ if Yes, what have you tried?_____

Rate the your pain from 1 to 10 (ten being excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4) PAST MEDICAL HISTORY

Do you have any of the following medical conditions?

Anemia	**Yes☐**	**No☐**	**Heart Trouble**	**Yes☐**	**No☐**
Back / Spine pain	**Yes☐**	**No☐**	**High Blood Pressure**	**Yes☐**	**No☐**
Blood Disease	**Yes☐**	**No☐**	**High Cholesterol**	**Yes☐**	**No☐**
Cancer	**Yes☐**	**No☐**	**HIV / AIDS**	**Yes☐**	**No☐**
Circulation Problems	**Yes☐**	**No☐**	**Kidney Disease**	**Yes☐**	**No☐**
Depression	**Yes☐**	**No☐**	**Leg Cramps**	**Yes☐**	**No☐**
Diabetes	**Yes☐**	**No☐**	**Osteoporosis**	**Yes☐**	**No☐**
Epilepsy/Seizure	**Yes☐**	**No☐**	**Rheumatic Disease**	**Yes☐**	**No☐**
Eye Disease	**Yes☐**	**No☐**	**Swelling of limbs**	**Yes☐**	**No☐**
Gout	**Yes☐**	**No☐**	**Stomach Trouble**	**Yes☐**	**No☐**
Hepatitis	**Yes☐**	**No☐**	**Stroke**	**Yes☐**	**No☐**
Headaches	**Yes☐**	**No☐**	**Tuberculosis**	**Yes☐**	**No☐**

Other **Yes☐** **No☐** **(list)**_____

Which of the above illnesses are in your immediate family?_____

List ANY medications you take prescription or over the counter:_____
_____

Do you have any allergies to medication? (if so, list)_____

List ALL major injuries, surgeries and hospitalizations:_____
_____

Are you pregnant or nursing? (if applicable) **Yes☐ No☐**

5) SOCIAL HISTORY

Marital status / Living arrangement ☐ Single ☐ Married ☐ Other_____
Do you use tobacco products? Yes☐ No☐ If yes, what type/ amount/ how long?_____
Do you use illegal drugs Yes☐ No☐ If yes, what type/ amount/ how long?_____
Do you drink alcohol? Yes☐ No☐ If yes, what / how much / how often?_____
Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? Yes☐ No☐
Hobbies & Activities?_____

6) REVIEW OF SYSTEMS

Do you currently have or chronically suffer from any of the following conditions?

INTEGUMENTARY (Skin)

☐ Deformed nails	☐ Itching	☐ Ulcerations
☐ Discolorations	☐ Skin Cancers	☐ Warts
☐ Eczema / Psoriasis	☐ Skin Rash	☐ Other_____

HEMATOLOGIC (blood)

☐ Bleeding disorder	☐ Take aspirin	☐ Take coumadin

NERVOUS

☐ Muscle jerking	☐ Paralysis	☐ Weakness
☐ Numbness / Burning	☐ Sciatica	☐ Other_____

MUSCULOSKELETAL

☐ Arthritis	☐ Sprains	☐ Tendonitis
☐ Fractures	☐ Stiffness	☐ Other_____

I hereby give Head to Toe Healthcare, PLC permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered and, if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I also authorize payment of medical benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill.

****As a Courtesy, we will bill your insurance company for you****

Signature_____ **Date:**_____