

HEALTH QUESTIONNAIRE

PLEASE DESCRIBE YOUR PRESENT FOOT/ANKLE PROBLEM \_\_\_\_\_  
IS YOUR PROBLEM THE RESULT OF AN ACCIDENT?... YES/NO WAS IT WORK RELATED?... YES/NO

HAVE YOU EXPERIENCED AN ALLERGIC REACTION FROM ANY MEDICATION?... YES/NO  
IF YES, PLEASE EXPLAIN \_\_\_\_\_ EMAIL: \_\_\_\_\_

ARE YOU PRESENTLY TAKING ANY MEDICATIONS?..... YES/NO  
PLEASE LIST THE MEDICATIONS \_\_\_\_\_

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING:

ASTHMA.....YES/NO	DIABETES.....YES/NO	HEART DISEASE... YES/NO
KIDNEY AILMENT.... YES/ NO	BLOOD PRESSURE.....YES/NO	STOMACH ULCER... YES/NO
LIVER AILMENT..... YES/NO	TUBERCULOSIS.....YES/NO	ARTHRITIS..... YES/NO
ANEMIA.....YES/NO	EPILEPSY/SEIZURES... YES/NO	CANCER..... YES/NO
HEPATITIS.....YES/NO	THYROID DISORDERS... YES/NO	HIV+/AIDS.....YES/NO

HAVE YOU HAD ANY INJURIES OR SURGERIES IN THE PAST?..... YES/NO  
IF YES, PLEASE EXPLAIN \_\_\_\_\_

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN DIAGNOSED WITH THE FOLLOWING:

ADHD.....YES/NO	AIDS/HIV+.....YES/NO	AUTISM.....YES/NO
BIPOLAR DISORDER. YES/NO	DEMENTIA.....YES/NO	DEPRESSION.....YES/NO
DIABETES.....YES/NO	HEART DISEASE... YES/NO	GASTRIC DISEASE... YES/NO
ARTHRITIS.....YES/NO	KIDNEY AILMENT... YES/NO	LIVER AILMENT..... YES/NO
CANCER.....YES/NO	IF SO, PLEASE SPECIFY _____	

DO YOU SMOKE?... YES/NO IF YES, ARE YOU A MODERATE OR HEAVY SMOKER? \_\_\_\_\_

DO YOU DRINK ALCOHOL?... YES/NO

ARE YOU CURRENT WITH YOUR IMMUNIZATIONS... YES/NO

HAVE YOU HAD A TETANUS SHOT WITHIN THE PAST 10 YEARS?.... YES/NO