HEALTH QUESTIONAIRE

Name:_____ Date: _____

Height: _____ Weight: _____Shoe Size: _____

Primary Care Physician: _____Physician's Phone Number: _____

Present Health

1. Are you being treated by any doctor for any condition? If yes, what condition: _____

_____

2. Do you take aspirin daily? If yes, how much? _____ 3. Are you pregnant? YES NO

4. Are you Diabetic? YES NO If yes, how is your Diabetes being controlled? DIET MEDICATION INSULIN

5. Are you taking any medication? (Please list)

1. _____ Strength_____ Dose_____
2. _____ Strength_____ Dose_____
3. _____ Strength_____ Dose_____
4. _____ Strength_____ Dose_____
5. _____ Strength_____ Dose_____
6. _____ Strength_____ Dose_____
7. _____ Strength_____ Dose_____
8. _____ Strength_____ Dose_____

6. List all **major surgeries** you've had **within the last 5 years**:

_____ Estimated Date _____
_____ Estimated Date _____
_____ Estimated Date _____
_____ Estimated Date _____

Do you have any of the following:

Skin disease _____	YES	NO	Frequent infections or boils _____	YES	NO
Heart trouble/heart attacks _____	YES	NO	Asthma _____	YES	NO
Swelling of hands, feet/ankles _____	YES	NO	High Blood Pressure _____	YES	NO
Liver disease _____	YES	NO	Hepatitis _____	YES	NO
Kidney disease _____	YES	NO	Varicose veins _____	YES	NO
Muscle or joint weakness _____	YES	NO	Difficulty walking _____	YES	NO
Urinary Tract Infection (last 6 mos.) _____	YES	NO	Psychiatric care _____	YES	NO
Slow to heal after cut _____	YES	NO	Drug or alcohol dependency _____	YES	NO
Anemia _____	YES	NO	Abnormal bruising/bleeding _____	YES	NO
Blood disease _____	YES	NO	Positive testing to HIV virus _____	YES	NO

Do you smoke?.....YES NO If yes, how much per day_____
Do you drink alcohol?.....YES NO If yes, how often_____

Are you allergic to: Latex……..YES NO Adhesive Tape…….YES NO Iodine……YES NO

Are you allergic to any medications? Please List:_____

Please list your reactions:_____