Health History Form

Carmel Valley Foot & Ankle Surgery — *Noushin Shoaee, DPM*

Name: _____

Height: **Weight:** **Shoe Size:**

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last ten years?
   Why? _____
4. Yes No Are you being treated by a physician? If so, for what? _____
   Date of last physical exam? _____
5. Yes No Have you ever been advised by a physician to take antibiotics prior to a procedure?
6. Yes No Are you in pain now?

II. ARE YOU CURRENTLY TODAY EXPERIENCING ANY OF THE FOLLOWING?

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath or wheezing?	20.	Yes	No	Headaches?
10.	Yes	No	Weight loss, fever, chills, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Fatigue?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD?

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS or HIV?
30.	Yes	No	Heart murmurs?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart attack, heart defects (explain)?	42.	Yes	No	(please circle) Arthritis, rheumatoid, or gout?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases? type
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases? type
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	(please circle) TB, emphysema, asthma, or other lung diseases?	46.	Yes	No	Diabetes? Insulin dependent? Y or N
36.	Yes	No	Hepatitis, other liver diseases?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers (circle)?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	STD (syphilis or gonorrhea)?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	ALLERGIES: to drugs, foods, latex, **list medications you are allergic to**?	50.	Yes	No	Family history (please circle and list family member) with diabetes, heart problems, cancer? Other_____

IV. DO YOU HAVE OR HAVE YOU HAD?

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatment for cancer?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries? List below #64
54.	Yes	No	Prosthetic heart valve(s)?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint(s)?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING?

61.	Yes	No	Tobacco in any form?	65.	Yes	No	Do you take diet pills?
62.	Yes	No	Alcohol? Mild, mod, or heavy	66.	Yes	No	Recreational or illegal drugs?

63. **Please list all medications:**

64. **Please list all operations:**

VI. WOMEN ONLY:

67.	Yes	No	Are you (please circle): trying to get pregnant, pregnant or nursing?	68.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

69. Yes No Do you have or have had any other diseases or medical problems NOT listed on this form?
    If so, please explain:
70. Yes No Have you or any family member ever had any adverse reaction to general anesthesia or a condition called malignant hyperthermia?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my surgeon of any change in my health and/or medication.

Patient's signature _____ Date: _____ Doctor's Signature: _____