DEANNA L. INLOW, DPM

Patient Name:______________________________ Weight:_______ Height:_______ Shoe Size: _____

HEALTH QUESTIONNAIRE

1) **Any allergies to medications or foods?** ❑ **YES** ❑ **No Know Drug Allergies**
   If yes, please list:

Allergic to	Reaction	Severity
		❑ Mild ❑ Moderate ❑ Severe
		❑ Mild ❑ Moderate ❑ Severe
		❑ Mild ❑ Moderate ❑ Severe
		❑ Mild ❑ Moderate ❑ Severe

2) **a. Do you have a family physician or a private physician** ❑ **YES** ❑ **NO**
   If yes, please list name and address: __________________________________
   ____

   b. Please list any additional providers on your care team
   ____
   ____

3) **Have you had any previous surgery?** ❑ **YES** ❑ **NO**
   If yes, please list:

Procedure/Surgery	Date

4) **Do you have or have had any problems with abnormally bleeding?** ❑ **YES** ❑ **NO**

5) **Have you had any major traumas (fractures, etc.)?** ❑ **YES** ❑ **NO**

6) **Have you been hospitalized over the past two years?** ❑ **YES** ❑ **NO**

7) **Do you have any known contagious diseases?** _________________________ ❑ **YES** ❑ **NO**

8) **WOMEN: Are you pregnant or think you may be pregnant?** ❑ **YES** ❑ **NO**

9) **Do you have an electronic implant or device** ❑ **YES** ❑ **NO**
   *If yes, please provide name of device, type, and serial number:*___________
   ____

Please provide other health information you deem important: ______________________________
____
____

Patient/Guardian Signature: ____ **Date:** ____________

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