Southern Nevada Foot and Ankle Center
3131 W. Charleston Blvd Suite 110, Las Vegas, NV 89102
(702) 878-5252 (702) 878-1963 fax

Health History Questionnaire

(please fill out completely)

Patient Name:_____DOB_____

Sex: M F Age: _____

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Referring Physician: _____

PCP/ Family Physician: _____

Current Problem: What is your current complaint or foot/ankle problem?

_____

_____

_____

Past Medical History:
Any prior foot and/or ankle surgeries Y N If yes, where and when?

_____

_____

_____

Any other surgeries? _____

Current medical history: Please list ALL health conditions you are currently being treated for:

Diabetes Type I Diabetes Type 2 Kidney disease Stroke Heart Attack
Hypertension Hypotension Anemia Liver Disease
Ay others?

_____

_____

_____

Current medications:
What medications and/or over-the-counter medications are you taking?

_____

_____

Allergies: Tape Penicillin Sulfa Codeine

Other Drug Allergies:

_____

_____

Family medical history:

Mother: _____ Father: _____

Other:

_____

_____

Social history:

Do you smoke? Y N Do you drink alcohol? Y N Occasionally Moderately Frequently

Review of systems: Are you having any problems with any of the following:

Lungs	Heart	Kidneys	Nerves	Liver	Head/Neck
Eyes	Skin	Ears	Nose	Throat	

Musculoskeletal Urine Stomach

If yes, please list symptoms:

_____

_____

Patient /Responsible Party Signature:

_____Date:_____