**Carl R. Wagreich, D.P.M.**
**Diplomate, American Board of Podiatric Surgery**
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**Phone 310-373-0521 FAX 310-791-1691**

Date: _____

Mr. Mrs. Miss Ms. Dr. (Circle one)

Last First Initial Age Birthdate Spouse

Home Address City State ZIP

Home Phone Cell# Work Phone Social Security Number

Drivers Lic. # Nearest Relative Name Address Phone

Chief Foot Complaint: _____

Previous foot care? _____ Doctor's Name _____

Date of last foot x-rays _____ Type of care: _____

Primary Care Physician: _____ Referred by: _____

**Do you now have, or have you ever had a history of:**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Heart Trouble | | | Yes | _____ | No _____ |
| 2. | Rheumatic Fever | | | Yes | _____ | No _____ |
| 3. | High Blood Pressure | | | Yes | _____ | No _____ |
| 4. | Sensitivity to any drug including Penicillin or Novocain | | | Yes | _____ | No _____ |
| 5. | Hay Fever, Asthma, Allergies, including adhesive tape | | | Yes | _____ | No _____ |
| 6. | Kidney or Liver Disease | | | Yes | _____ | No _____ |
| 7. | Hepatitis or other blood diseases | | | Yes | _____ | No _____ |
| 8. | Diabetes | | | Yes | _____ | No _____ |
| 9. | Fainting or dizzy spells | | | Yes | _____ | No _____ |
| 10. | Excessive bleeding from cuts | | | Yes | _____ | No _____ |
| 11. | Are you under the care of a doctor now | | | Yes | _____ | No _____ |
| 12. | Are you taking any medication now - list below | | | Yes | _____ | No _____ |
| 13. | Any recent illness | | | Yes | _____ | No _____ |
| 14. | Number of Children _____ | Are you pregnant now | | Yes | _____ | No _____ |

Employed by _____ Occupation _____

Address _____

Spouse's employer _____ Occupation _____

Address _____ Work phone _____

Health Insurance Company _____

Signed: _____

# Carl R. Wagreich, D.P.M., D.A.B.P.S.
# Health Questionnaire

## List of past illness - Have you had:

| | | | | |
|---|---|---|---|---|
| Measles | No | _____ | Yes | _____ |
| Mumps | No | _____ | Yes | _____ |
| Chicken Pox | No | _____ | Yes | _____ |
| Diabetes | No | _____ | Yes | _____ |
| Stroke | No | _____ | Yes | _____ |
| Cancer | No | _____ | Yes | _____ |
| Rheumatic fever or heart disease | No | _____ | Yes | _____ |
| Tuberculosis | No | _____ | Yes | _____ |
| Venereal Disease | No | _____ | Yes | _____ |
| Congenital Abnormalities | No | _____ | Yes | _____ |
| Other serious diseases | No | _____ | Yes | _____ |
| Have you had any serious illnesses? | No | _____ | Yes | _____ |

How much time have you lost from work because of your health during the past:

Six Months _____

Year _____

Five Years _____

Have you ever been hospitalized or been under medical care for an extended duration?

No _____ Yes _____

If yes, for what reason: _____

_____

## Operations:

Have you had any surgeries?

No _____ Yes _____

List: _____

_____

_____

## Injuries:

| | | | | |
|---|---|---|---|---|
| Have you had any broken bones? | No | _____ | Yes | _____ |
| Have you had any head concussions or injuries? | No | _____ | Yes | _____ |
| Have you ever been knocked unconscious? | No | _____ | Yes | _____ |

## Family History - Has any blood relative ever had:

| | | | | |
|---|---|---|---|---|
| Cancer | No | _____ | Yes | _____ |
| Tuberculosis | No | _____ | Yes | _____ |
| Diabetes | No | _____ | Yes | _____ |
| Heart trouble | No | _____ | Yes | _____ |
| High blood pressure | No | _____ | Yes | _____ |
| Stroke | No | _____ | Yes | _____ |
| Convulsions | No | _____ | Yes | _____ |
| Suicide | No | _____ | Yes | _____ |
| Insanity | No | _____ | Yes | _____ |
| Bleeding tendency | No | _____ | Yes | _____ |
| Gout or arthritis | No | _____ | Yes | _____ |

## Social History:

| | | | | |
|---|---|---|---|---|
| Alcoholic Beverages | No | _____ | Yes | _____ |
| Never | | _____ | | |
| Rarely | | _____ | | |
| Moderately | | _____ | | |
| Daily | | _____ | | |
| Tobacco | No | _____ | Yes | _____ |
| Cigarettes | No | _____ | Yes | _____ |
| Packs per day | | _____ | | |
| Never | | _____ | | |
| Education (yrs completed) | | _____ | | |
| Grade school | | _____ | | |
| High School | | _____ | | |
| College | | _____ | | |
| Post graduate | | _____ | | |
| Are you employed? | No | _____ | Yes | _____ |

Are you exposed to fumes, dusts or solvents?

No _____ Yes _____

What is your occupation?

_____

_____

## SYSTEMIC REVIEW - do you have any of the following?

Recent weight change No _____ Yes _____

Have you been in general good health most of your life?

No _____ Yes _____

### Skin:

Skin disease No _____ Yes _____
Jaundice No _____ Yes _____
Hives, eczema or rash No _____ Yes _____
Frequent infection or boils No _____ Yes _____
Abnormal pigmentation No _____ Yes _____

### Head, Eyes, Ears, Nose or Throat

Eye disease or injury No _____ Yes _____
Double vision No _____ Yes _____
Headaches No _____ Yes _____
Glaucoma No _____ Yes _____
Itching eyes or nose No _____ Yes _____
Sneezing No _____ Yes _____
Nosebleeds No _____ Yes _____
Chronic sinus trouble No _____ Yes _____
Ear disease No _____ Yes _____
Impaired hearing No _____ Yes _____
Dizziness or unconsciousness No _____ Yes _____

### Neck:

Stiffness No _____ Yes _____
Thyroid trouble No _____ Yes _____
Enlarged glands No _____ Yes _____

### Respiratory:

Cold now No _____ Yes _____
Spitting up blood No _____ Yes _____
Chronic or frequent cough No _____ Yes _____
Asthma or wheezing No _____ Yes _____
Difficulty breathing No _____ Yes _____
Any trouble with lungs No _____ Yes _____
Pleurisy or Pneumonia No _____ Yes _____

### Cardiovascular

Chest pain or angina pectoris No _____ Yes _____
Shortness of breath when walking or lying down No _____ Yes _____
Difficulty walking two blocks No _____ Yes _____
Heart trouble or heart attacks No _____ Yes _____
High blood pressure No _____ Yes _____
Swelling of hands, feet or ankles No _____ Yes _____
Awakening in the night smothering No _____ Yes _____
Heart murmur No _____ Yes _____

### Gastrointestinal

Peptic ulcer (stomach or duodenal) No _____ Yes _____
Vomiting blood or food No _____ Yes _____
Gallbladder disease No _____ Yes _____
Liver trouble No _____ Yes _____
Hepatitis No _____ Yes _____
Painful bowel movements No _____ Yes _____
Black stools No _____ Yes _____
Hemorrhoids or piles No _____ Yes _____
Recent change in bowel habits No _____ Yes _____
Frequent Diarrhea No _____ Yes _____
Heartburn or indigestion No _____ Yes _____
Cramping or pain in the abdomen No _____ Yes _____
Does food stick in throat No _____ Yes _____

### Genitourinary

Loss of urine No _____ Yes _____
Frequent urination No _____ Yes _____
Night time urinating No _____ Yes _____
Burning or painful urination No _____ Yes _____
Blood in urine No _____ Yes _____
Kidney stones or trouble No _____ Yes _____
Bright's Disease No _____ Yes _____

### Locomotor –Musculoskeletal

Varicose veins No _____ Yes _____
Weakness of muscles or joints No _____ Yes _____
Any difficulty in walking No _____ Yes _____
Any pain in calves or buttocks on walking relieved by rest No _____ Yes _____

## Neuro-Psychiatric

| | | | | |
|---|---|---|---|---|
| Have you every had psychiatric care | No | _____ | Yes | _____ |
| Have you been advised to see a psychiatrist | No | _____ | Yes | _____ |
| Did you every have fainting spells | No | _____ | Yes | _____ |
| Convulsions | No | _____ | Yes | _____ |
| Paralysis | No | _____ | Yes | _____ |

## Hematologic

| | | | | |
|---|---|---|---|---|
| Are you slow to heal after cuts | No | _____ | Yes | _____ |
| Blood disease | No | _____ | Yes | _____ |
| Anemia | No | _____ | Yes | _____ |
| Phlebitis | No | _____ | Yes | _____ |

Have you had any difficulty with bleeding excessive after tooth extractions or surgery

No _____ Yes _____

Have you had abnormal bruising or bleeding No _____ Yes _____

## Endocrine

| | | | | |
|---|---|---|---|---|
| Thyroid disease | No | _____ | Yes | _____ |
| Hormone therapy | No | _____ | Yes | _____ |

## Gynecological

How long do periods last _____

Frequency of periods, every _____ days

Number of pregnancies _____

miscarriage _____

Date of last Pap smear _____

Any pain with periods No _____ Yes _____

Date of first day of last period _____

Are you pregnant now No _____ Yes _____

## Allergies and Sensitivities

| | | | | |
|---|---|---|---|---|
| Is there a history of skin reaction or sickness following injection or oral administration of: | No | _____ | Yes | _____ |
| Penicillin or other antibiotic | No | _____ | Yes | _____ |
| Morphine, Codeine, Demerol or other narcotics | No | _____ | Yes | _____ |
| Novocain or other anesthetics | No | _____ | Yes | _____ |
| Aspirin, empirin or other pain remedies | No | _____ | Yes | _____ |
| Sulfa drugs | No | _____ | Yes | _____ |
| Tetanus antitoxin or other serums | No | _____ | Yes | _____ |
| Adhesive tape | No | _____ | Yes | _____ |
| Iodine or merthiolate | No | _____ | Yes | _____ |

Any other drug or medications _____

List: _____

## Drugs recently taken (within the past six months)

| | | | | |
|---|---|---|---|---|
| Cortisone | No | _____ | Yes | _____ |
| ACTH | No | _____ | Yes | _____ |
| Anticoagulants | No | _____ | Yes | _____ |
| Tranquilizers | No | _____ | Yes | _____ |
| Hypotensives (high blood pressure) | No | _____ | Yes | _____ |
| Aspirin | No | _____ | Yes | _____ |
| Birth Control pills | No | _____ | Yes | _____ |

Other: _____

**Height** _____

**Weight** _____

Source of information, if other than patient: _____

Signed: _____

Date: _____