Serenity Well-Being Clinic, P.A.
Comprehensive Podiatric Care

2701 Park Drive, Suite 6
Clearwater, FL 33763
727-631-1592

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Height:	**Weight:**
Family Doctor:	**Date of last physical exam:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY				
Tetanus Immunizations and dates:	☐ Current	☐ Over 5 Years	☐ Over 10 Years	☐ Unknown

List any medical problems that other doctors have diagnosed		
Pharmacy Name(s) and Phone Number(s)		

Previous Injuries		
Year	Reason	Hospital

Previous Surgeries		
Year	Reason	Hospital

Previous Hospitalizations		
Year	Reason	Hospital

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and supplements		
Name the Drug	Strength	Frequency Taken

Allergies (List Medication, food and environmental allergies)	
Name	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY							
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.							
Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Alcohol	Do you drink alcohol?				☐ Yes	☐ No	
	If yes, what kind?						
	How many drinks per week?						
Tobacco	Do you use tobacco?				☐ Yes	☐ No	
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day			
	☐ # of years	☐ Or year quit					
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No	
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No	

OTHER PROBLEMS
Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

Major Disease	**Vascular**	**HEENT**	**Gastrointestinal**	**Miscellaneous**
☐ Diabetes	☐ Anemia	☐ Headaches	☐ Ulcers	☐ Epilepsy
☐ Hypertension	☐ Sickle Cell	☐ Migraines	☐ Upset Stomach	☐ Thyroid Disease
☐ Angina	☐ Night Cramps	☐ Hearing Problems	☐ Bowel Disorder	☐ Muscle Disease
☐ Heart Disease	☐ Bleeding Disorder	☐ Eye Problems	☐ GI/Rectal Bleed	☐ Kidney Problems
☐ Murmur	☐ Poor Circulation	**Respiratory**	☐ GERD	☐ Bladder Problems
☐ Heart Attack	☐ Vein Problems	☐ Asthma	☐ Hiatal Hernia	☐ Prostate Problems
☐ Stroke	☐ Blood Clots	☐ Bronchitis		☐ Skin Conditions
☐ Chest Pain	☐ Varicose Veins	☐ Frequent Colds	**Psychological**	☐ Venereal Disease
☐ Arrhythmia	☐ Swelling	☐ Lung Disease	☐ Anxiety	☐ Cancer History
Arthritis	☐ Leg Ulcerations	☐ Tuberculosis	☐ Depression	☐ Hepatitis
☐ Osteoarthritis	☐ Phlebitis	☐ Emphysema	☐ Drug Abuse	☐ Autoimmune Disease
☐ Rheumatoid	☐ Gangrene	☐ Shortness of Breath	☐ Alcohol Abuse	☐ HIV Positive
☐ Gout	☐ Rest Pain	**Other**		
☐ Sero-negative	☐ Spider Veins			

I hereby give my permission to Dr. Roboubi to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I certify that the above information is true and correct to the best of my knowledge.

Signature of Responsible Party: _____ **Date:** _____