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DELAND FOOT AND LEG CENTER 844 N. Stone St., Ste 208, DeLand, FL 32720
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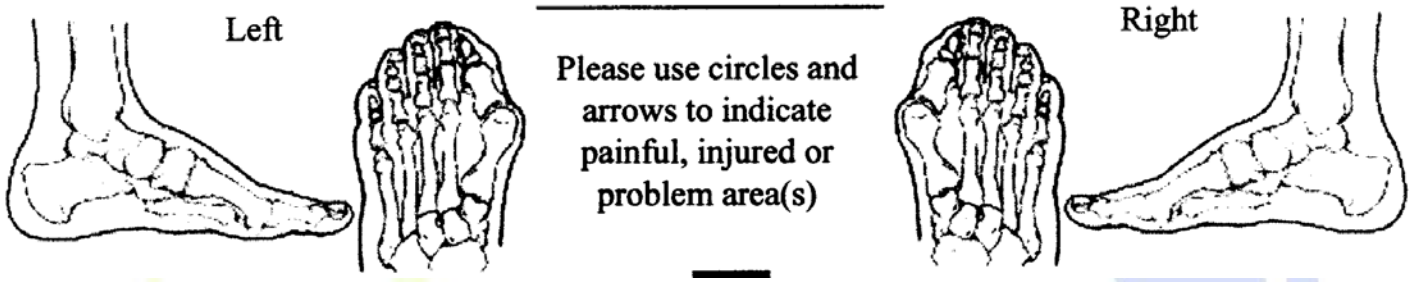
PATIENT INITIAL HISTORY QUESTIONNAIRE

Everything I answer is true, complete, and correct to the best of my knowledge. Failure to provide a truthful and complete medical history may result in serious complications, harm**, or discharge from this office**. You may be required to provide more medical information so that we can give you the best care and assessment.

Patient Name: _____ Date: _____

Date of Birth: _____ (Office use only) MR#_____

Family/Primary Doctor: _____ Who referred you to us?_____



REASON FOR VISIT: _____

HOW LONG HAS THIS PROBLEM BEEN PRESENT?_____

THE PROBLEM IS: ☐Improving ☐Getting Worse ☐Not Changing

THE PAIN SCALE IS: 0 1 2 3 4 5 6 7 8 9 10 (worst**)**

Other Physician's you have seen for this problem: _____

ARE YOU TAKING ANY MEDICATION FOR THIS PROBLEM?_____

DOES THE MEDICATION HELP? ☐Yes ☐No

WHAT AGGREVATES THE PROBLEM? _____

WHEN IS THE PROBLEM WORSE? ☐Morning ☐End of day ☐While sleeping

ALLERGIES: ☐ **No Known Drug Allergies** Name of Drugs: _____

Ongoing Medical Problems: ☐ **No Known Medical Problems**

☐ Hypertension	☐ Atherosclerosis	☐ Vascular disease	☐ Elevated Cholesterol
☐ Insulin Diabetes	☐ Asthma	☐ Past heart attack	☐ Bi-polar, depression
☐ Non-insulin Diabetes	☐ Ulcers	☐ Hepatitis A/ B / C	☐ Renal problem
☐ Cancer	☐ Tuberculosis	☐ Liver disease	☐ GI problems
☐ Seizure disorders	☐ Thyroid Disorder	☐ Emphysema	☐ Fibromyalgia
☐ COPD/Lung dz	☐ Immune Disorder	☐ Overweight	☐ Arthritis: knee, hip, wrist, etc
☐ Osteomyelitis	☐ DVT	☐ Varicose veins	☐ Back pain/problems
☐ Leg cramps	☐ Anxiety	☐ Neuropathy	☐ Others: _____

Major Medical Event or Hospitalization for: ☐ **No Significant History**

_____

_____

PAST SURGICAL HISTORY:

☐ **No Previous Surgeries**

☐ Hysterectomy	☐ Appendectomy	☐ Lumbar laminectomy
☐ Cataract extraction	☐ Mastectomy	☐ By-pass / open heart
☐ Tonsillectomy	☐ Gall bladder	☐ Prostate surgery
☐ Hernia repair	☐ Foot Surgery	☐ Other:_____

FAMILY HISTORY: (MUST BE UP TO DATE)

_____

_____

_____

PREVENTATIVE CARE & PHARMACY:

(NO PRESCRIPTIONS WILL BE FILLED WITHOUT A LISTED PHARMACY**)**

_____

_____

_____

NUTRITION (VITAMINS,DIET RESTRICTIONS): ☐ **Normal**

_____

_____

DEVELOPMENTAL/PEDIATRIC HISTORY: ☐ **Normal**

_____

HOW MUCH ALCOHOL DO YOU CONSUME?

A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only
(E) An average of 1-2 drinks per day
(F) An average of 3 or more

TOBACCO USAGE:

(A) Yes, I am currently a smoker or use tobacco
I smoke (circle one) 1 2 3 packs/day
I have smoked for _____ years
(B) No, but I did for _____ years
(C) No, I have never used tobacco

I WORK: _____ ☐ **I DO NOT WORK**

I LIVE WITH:_____

MEDICATIONS: ☐NONE ☐See List

Dr. Pulapaka will not prescribe medication if the medical history or medication list is not complete.

NAME	DOSE

THE FOLLOWING CHECK MARKS INDICATE ABNORMALITIES:

☐ **I HAVE NO PROBLEMS**

☐ blurred vision ☐headaches ☐ stiffness ☐ difficulty swallowing
☐ chest pain ☐ palpitations ☐ SOB ☐ coughing
☐ nausea ☐vomiting ☐ frequent urination
☐ leg cramping ☐ resting pain in toes ☐ swelling
☐ arthritis ☐ joint pain ☐ total joint implant

_____

Patient or Guardian's Signature / Date

THIS WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD AT DELAND FOOT AND LEG CENTER, LLC
.Part 2: Patient Questionnaire to be signed after the information has been entered into the system by medical staff.
Dr. Pulapaka does not prescribe medication if the medical history or medication list is not complete.