

(a D/B/A of Michael H. Loshigian DPM PC)

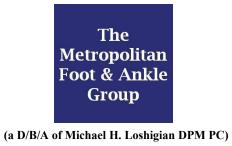
Patient Health History Questionnaire

Last Name:	First Name	<u> </u>	Date of Birth:		
Past Medical History		NO Past Medical H	listory		
Acid Reflux	Crohn's Disease/IBS	Low Blood Pressure	·		
Alzheimer's Disease	Diabetes – Type	Liver Problems	Swollen Glands		
Angina Angina	Emphysema/COPD	Lung Problems	Sleep Apnea		
Anemia	Gout	Lupus	Stomach Ulcer		
Asthma	Heart Attack	Mental Illness	Stroke		
Bleeding Disorder	Hepatitis	Morbid Obesity	Thyroid Disorder		
Blood Clots / DVT	Herpes Zoster	Neuropathy	Tuberculosis		
Cancer	Hemophilia	Phlebitis	Venereal Disease		
High Cholesterol	High Blood Pressure	Psychiatric Care	Weight Loss		
Chemical Dependency	HIV or AIDS	Rheumatic Fever	Other		
Congestive Heart Failure		Schizophrenia			
Past Podiatric Medical History NO Past Podiatric Medical History					
Ankle or Foot pain	Dislocations	Herniated Disc	Pain – Knee		
Athlete's Foot	Fibromyalgia	Ingrown Toenails	Psoriatic Arthritis		
Arthritis	Flat Feet	Multiple Sclerosis	Plantar Warts		
Bunions	Fractures	Neuroma	Rheumatoid Arthritis		
	=	Numbness in Feet			
Bursitis	Foot or Leg Cramps	=	Scoliosis Garagina/Strains		
Cerebral Palsy	Ganglion Cyst	Osteopenia	Sprains/Strains		
Corns/Calluses	Heel Pain	Osteoporosis	Swelling of Joints		
Cellulitis/Infection	Heel Spur	Pain – Back	Tarsal Tunnel Syndrome		
Past Surgical History		NO Past Surgical H	listory		
Surgery(ies) you have had in the past:					
Family History		NO Family History			
	Diabetes	Gout	Mental Illness		
Stroke	Heart Problems	Hypertension	Other		
Work Status: Disabled [Homemaker On Leave	Retired Student [Unemployed Working		
Alcohol use? No Alcoho	ol Yes, consume alcohol	(drinks per day)	Social Drinker		
Tobacco use? Never	Current everyday Curr	ent occasional Form	nerly (Quit years ago)		
Recreational drug use?:	Never Currently	In the Past			
Are you Pregnant?	es No				



(a D/B/A of Michael H. Loshigian DPM PC)
Do you have any Drug Allergies?: Adhesive/Tape Aspirin Blood Thinners Codeine Iodine Local Anesthetics Penicillin Shellfish Sulfa Other
Are you currently taking any medications?
Chief Complaint: What is the main reason for your visit today? Describe the problem in detail. (What Hurts?)
Side: Left Right Both Area with most pain? Toes Top of Foot Bottom of Foot Ankle
How long have you had pain? Weeks Months Years Date of Injury(if applicable):
Is this injury: Work related? Motor Vehicle Accident related? Sports related? Trauma related?
What is your pain quality? Dull Sharp Achy Burning Stabbing Tingling Soreness
When is pain the worst? Morning Evening After Activity At Night (interferes with sleep)
Pain Level: 1 2 3 4 5 6 7 8 9 10
What actions/activities make the problem worse? Walking Standing Running Bending Lifting Reaching Driving Sitting Other:
What actions/activities make the problem better? Resting Ice Heat Elevation Pain Meds Activity Other
Are there any other associated signs or symptoms? Weakness Numbness/Tingling Radiating Pain Instability
Have you had any diagnostic studies or treatments for this problem? If so, when and where? X-Ray MRI EMG/NCV CT Ultrasound Physical Therapy Injections Bracing Surgery Other
Are there any specific treatment options that brought you to us? (i.e. Stem Cell, Visco-supplementation, PRP, Laser Treatment, Orthotics, etc)

Patient Name:



Patient Name:		
•	·	_

REVIEW OF SYSTEMS					
Please check any symptoms that you are currently experiencing.					
NONE of the below					
Constitutional: Chills Fever Headache Weight Gain/Loss Fatigue Body Ache					
Cardiovascular: Chest Pain Hypertension Palpitations Varicosities Rapid Heart Rate					
Genitourinary: Urine Hesitancy Incontinence Urinary Retention Hematuria					
Musculoskeletal: Back Pain Joint Swelling Joint Pain Neck Pain Ankle Instability Joint Stiffness Muscle Cramps Leg Cramps Muscle Weakness					
Hema-Lymph: Anemia Blood Clotting Swollen Glands Easy Bruising					
HEENT: Sore Throat Ear Infection Nasal Congestion Nose Bleeding Blurred Vision					
Respiratory: Shortness of Breath Wheezing Cough					
Gastrointestinal: Abdominal Pain Constipation Jaundice Diarrhea Nausea/Vomiting Ulcers					
Integumentary: Boils Itching Redness Skin Rash Open Wound					
Neurologic: Blackouts Dizziness Tingling/Numbness Seizures Tremors Sciatica					
Endocrine: Excessive Thirst Tired Too Cold/Hot					
Psychiatric: Depression Difficulty Sleeping Anxiety					
Allergic/Immunologic: Drug Allergies Hay Fever Runny Nose					
FOR OFFICE USE ONLY:					
<u>Treatment Consent:</u> I hereby consent and give my permission to the doctor (and doctor's assistant or					
designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.					

Name of Patient: _____ Date: _____

Relation to Patient:

Signature of Patient/Guardian: