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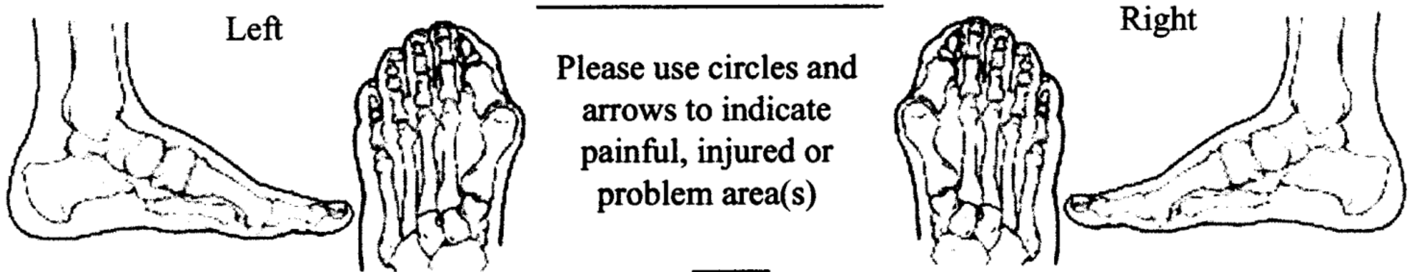
PATIENT INITIAL HISTORY QUESTIONNAIRE

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 ADDRESS/PHONE:
(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.