



PODIATRY ASSOCIATES OF FLORIDA, INC. YANT DIVISION

Podiatrist - Foot Specialist
Diplomate American Board of Podiatric Surgery

ROBERT D. YANT, D.P.M.
JOHN S. ANDERSON, D.P.M.

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

1. Allergies to Medication -

2. Current Medications - (Drug name, Milligrams, and Times per day)

3. What brings you into the office today?

4. List any Surgeries and Hospitalizations you've had and their approximate date -

5. Please check yes or no if you have any of the following:

- Yes ___ No ___ Diabetes
Yes ___ No ___ High blood pressure
Yes ___ No ___ Heart Disease
Yes ___ No ___ Gout
Yes ___ No ___ Rheumatic Fever
Yes ___ No ___ Skin Disorders
Yes ___ No ___ Blood Clots
Yes ___ No ___ Polio
Yes ___ No ___ Alcoholism/Drug Addiction
Yes ___ No ___ Female Problems
Yes ___ No ___ Neurological Disorders
Yes ___ No ___ Cancer
Yes ___ No ___ Hypercholesterolemia
Yes ___ No ___ Thyroid Disease
Yes ___ No ___ Poor Circulation
Yes ___ No ___ Seizures, Fainting Spells, Dizziness
Yes ___ No ___ Venereal Disease (Social)
Yes ___ No ___ Ulcers/Stomach Problems
Yes ___ No ___ Disease of the Digestive Tract
Yes ___ No ___ Disease of the Eye, Nose, Throat
Yes ___ No ___ Kidney Disease
Yes ___ No ___ Lung Disease
Yes ___ No ___ Sickle Cell Anemia
Yes ___ No ___ Treatment by a Psychiatrist
Yes ___ No ___ Others, if so what?

6. Do you smoke? Yes or No (circle which applies)

7. Do you drink? Yes or No (circle which applies) Rarely, daily or moderately (circle which applies)