



ORTHOPEDIC FOOT & ANKLE CENTER

Name: _____ Date of Exam: _____

Male/Female Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____ Usual Blood Pressure: _____ Usual Pulse: _____

Primary Care Physician: _____

How did you first hear about Orthopedic Foot & Ankle Center?

Physician or other health professional: _____

Friend/Family Member _____ Insurance Website Other

What foot or ankle concerns would you like addressed by your doctor today?

When did your condition begin? _____ Was it related to an injury? Yes No

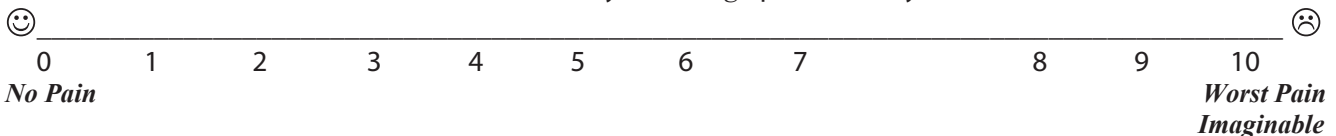
If so, what type of injury? _____

What bothers you most about your foot or ankle? Pain Swelling Feels Unstable Deformity

What distance can you walk before your symptoms begin?

Unlimited distances 4 to 6 blocks 1 to 3 blocks Less than 1 block

Mark the scale with a vertical line to indicate your *average* pain due to your foot and ankle condition.



Which activities make your symptoms worse?

Walking Running Uneven ground Certain shoes Getting up from a seated position

Which of the following treatments have you tried?

Anti-inflammatory Medications Physical Therapy Shoe Modification/Inserts
 Cortisone Injections Bracing Surgery

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Don't forget to complete reverse side

List any diagnostic studies (MRI, CT, Bone scan, Vascular Studies, EMG) you've had for this condition along with a date and location of where the study was performed.

1. _____ 3. _____
2. _____ 4. _____

List any surgical procedures with year, starting with most recent.

1. _____ 3. _____
2. _____ 4. _____

List all your current medications

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies: No Yes Please list: _____

Do you participate in any Sports or regular exercise activity? Yes No If Yes, what type? _____

What activities or hobbies do you enjoy during your free time? _____

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How often? _____

Personal Medical History

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding/bruising tendency |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/Emphysema/wheezing |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Pulmonary Embolism (blood clot in lung) |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Transplant or Dialysis |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Ulcers |

Review of Systems

Please check all that apply (recent or current only):

- | | |
|---|---|
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Pain with Swallowing | <input type="checkbox"/> Cold Hands or Feet |
| <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Joint Stiffness/Swelling | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vomiting |

If any apply, please explain: _____

Please list any medical conditions that run in your family (Mother, Father, Siblings, Grandparents)

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