ORTHOPEDIC FOOT & ANKLE CENTER

Name: _____ Date of Exam: _____

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

Occupation: _____ Usual Bl ood 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.

☺ _____ ☹

0 1 2 3 4 5 6 7 8 9 10

No Pain ***Worst Pain Imaginable***

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

Internal Office Use Only

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:

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

Review of Systems

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

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

If any apply, please explain: _____

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

_____

Internal Office Use Only