Provider Reviewed & Dictated

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?

____

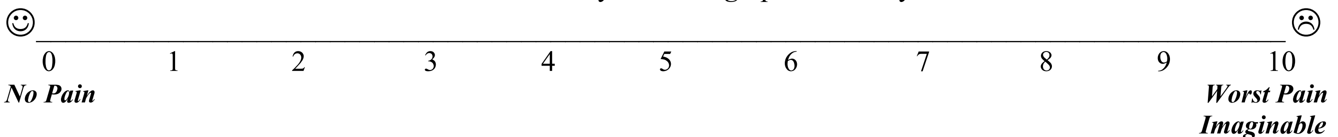
When did your condition begin? ____________________Was it related to an injury? ☐ Yes ☐ No

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.



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 - Medication/Dose/Frequency____________________
☐ Physical Therapy - Start Date & Frequency____________________
☐ Cortisone Injections - Date of Injections ____________________
☐ Shoe Modification/Inserts ☐ 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. ____________________

Are you currently being treated by a pain specialist? ☐ Yes ☐ No Name: ____________________

Allergies: ☐ No ☐ Yes Please list: ____________________

Pharmacy Name: __________ Address: ____________________ Phone: __________

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)

____

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