Foot And Ankle Specialists

Patient Name ______________________________ Date Of Birth _______________Today's Date ________

REFERRAL SOURCE:

How did you hear about us?

□ Doctor: __________________________________ □ Hospital: _________________________________

□ Internet □ Insurance □ Famly/Friend □ Newspaper □ Drive By □ Employee □ Phone Book

HISTORY OF PRESENT ILLNESS/WHAT BRINGS YOU IN TODAY?

What is your specific foot/ankle problem?
____
____
____

When did the problem begin? _________________________
____

What improves the problem? __________________________

Is the problem Painful? □ Yes □ No

If the problem is painful, please rate your pain:

(none) 1 2 3 4 5 6 7 8 9 10 (worst)

Is this from an injury? □ Yes □ No

If yes, is it work related? □ Yes □ No

If work related- Date of injury: _________________________

What Foot/Ankle is involved? □ Right □ Left □ Both

Have you had similar problems in the past? □ Yes □ No

How was the problem onset? □ Sudden □ Gradual

The problem is worst: □AM □PM □At Rest □W/Activity

What Aggravates the problem? _____________________
____

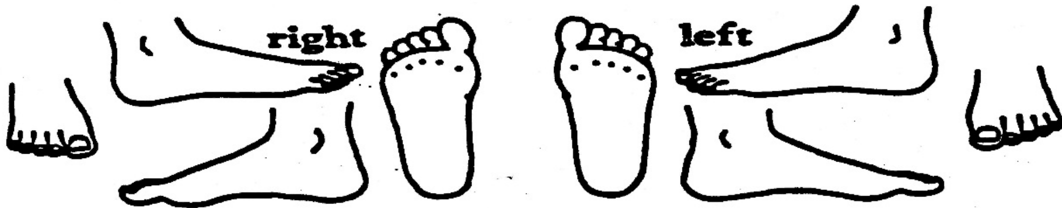
Describe previous treatment: ______________________
____

Describe the pain: □ Sharp □ Dull □ Aching □Throbbing

□ Cramping □ Itching □ Popping □ Burning □Tingling

□ Clicking □ Shooting □ Stabbing □ Other: ___________
____

INDICATE AREA OF PAIN ON THE DIAGRAM BELOW



Have you had any of the following diagnostic studies for your current problem?

Diagnostic X-rays	□ yes	□ no	Date: _________
CT (computed tomography)	□ yes	□ no	Date: _________
MRI (magnetic resonance imaging)	□ yes	□ no	Date: _________
Epidural Steroid/ Facet Block injection	□ yes	□ no	Date: _________
EMG (electromyogram)/ NCV (nerve conduction velocity	□ yes	□ no	Date: _________

<u>If you have a disc of any of these images please give them to the receptionist ASAP</u>

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REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Recent Weight Changes
- ☐ Fever/Chills
- ☐ Nausea or Vomiting
- ☐ Fatigue
- ☐ Night Sweats

PERIPHERAL VASCULAR
- ☐ Temperature Changes in Feet
- ☐ Swelling in hands or feet
- ☐ Burning Sensation
- ☐ Cramping in feet/Legs

INTEGUMENTARY
- ☐ Bruising
- ☐ Callus/Corns
- ☐ Cracked Heels
- ☐ Drainage
- ☐ Ingrown Toenail
- ☐ Itching
- ☐ Keloids
- ☐ Nail Changes
- ☐ Nail Thickening
- ☐ Nail Discoloration
- ☐ Peeling
- ☐ Redness
- ☐ Ulcers
- ☐ Warts

EYES
- ☐ Eye Disease
- ☐ Wear Glasses
- ☐ Blurred or Double Vision

EARS/NOSE/MOUTH/THROAT
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Sore Throat/Voice Change
- ☐ Sinus Problems
- ☐ Difficulty Swallowing

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic/Frequent Cough
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpations
- ☐ Arrhythmia/Irregular Heartbeat

GASTROINTESTINAL
- ☐ Indigestion/Heartburn
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Stomach Pains

GENITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Blood in Urine

MUSKULOSKELATAL
- ☐ Muscle Pain
- ☐ Joint Pain-Where: _______ ______________________
- ☐ Stiffness/Swelling Joints
- ☐ Low Back Pain
- ☐ Trouble Walking
- ☐ Toe Pain
- ☐ Heel Pain
- ☐ Tendon Pain
- ☐ Bone Pain
- ☐ Atrophy
- ☐ Limited Range of Motion
- ☐ Deformity
- ☐ Swelling
- ☐ Arch Pain

NEUROLOGICAL
- ☐ Migraines
- ☐ Muscle Weakness
- ☐ Frequent Headaches
- ☐ Numbness/Tingling
- ☐ Dizzy Spells
- ☐ Paralysis/Tremors
- ☐ Burning

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Confusion
- ☐ Memory Loss

ENDOCRINE
- ☐ Hormonal Problem
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Too Hot/Too Cold

VITALS

For Office Use Only:

Height ____________________

Weight ____________________

Blood Pressure ____________

Temperature ____________

Pulse ____________________

Respirations ____________

Shoe Size ____________

This document was reviewed by __________________________________, Podiatric Assistant Date: ___________

This document was reviewed by __________________________________ D.P.M. Date: ___________