

# Foot And Ankle Specialists

Patient Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

## REFERRAL SOURCE:

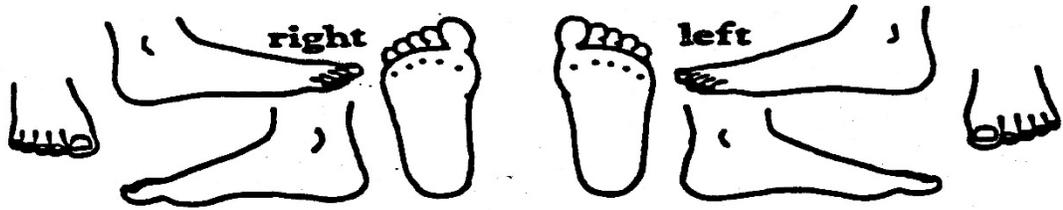
### How did you hear about us?

- Doctor: \_\_\_\_\_  Hospital: \_\_\_\_\_  
 Internet  Insurance  Family/Friend  Newspaper  Drive By  Employee  Phone Book

## HISTORY OF PRESENT ILLNESS/WHAT BRINGS YOU IN TODAY?

|   |  |
|---|--|
| <p>What is your specific foot/ankle problem?<br/>                 _____<br/>                 _____<br/>                 _____</p> <p>When did the problem begin? _____<br/>                 _____</p> <p>What improves the problem? _____</p> <p>Is the problem Painful? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the problem is painful, please rate your pain:<br/>                 (none) 1 2 3 4 5 6 7 8 9 10 (worst)</p> <p>Is this from an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, is it work related? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If work related- Date of injury: _____</p> | <p>What Foot/Ankle is involved? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both</p> <p>Have you had similar problems in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How was the problem onset? <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual</p> <p>The problem is worst: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> At Rest <input type="checkbox"/> W/Activity</p> <p>What Aggravates the problem? _____<br/>                 _____</p> <p>Describe previous treatment: _____<br/>                 _____</p> <p>Describe the pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Throbbing<br/> <input type="checkbox"/> Cramping <input type="checkbox"/> Itching <input type="checkbox"/> Popping <input type="checkbox"/> Burning <input type="checkbox"/> Tingling<br/> <input type="checkbox"/> Clicking <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Other: _____<br/>                 _____</p> |
|---|--|

## INDICATE AREA OF PAIN ON THE DIAGRAM BELOW



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

|   |  |             |
|---|--|-------------|
| Diagnostic X-rays                                     | <input type="checkbox"/> yes <input type="checkbox"/> no | Date: _____ |
| CT (computed tomography)                              | <input type="checkbox"/> yes <input type="checkbox"/> no | Date: _____ |
| MRI (magnetic resonance imaging)                      | <input type="checkbox"/> yes <input type="checkbox"/> no | Date: _____ |
| Epidural Steroid/ Facet Block injection               | <input type="checkbox"/> yes <input type="checkbox"/> no | Date: _____ |
| EMG (electromyogram)/ NCV (nerve conduction velocity) | <input type="checkbox"/> yes <input type="checkbox"/> no | Date: _____ |

**If you have a disc of any of these images please give them to the receptionist ASAP**

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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:

Weight \_\_\_\_\_

Height \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Temperature \_\_\_\_\_

Pulse \_\_\_\_\_

Respirations \_\_\_\_\_

Shoe Size \_\_\_\_\_

This document was reviewed by \_\_\_\_\_, Podiatric Assistant Date: \_\_\_\_\_

This document was reviewed by \_\_\_\_\_ D.P.M. Date: \_\_\_\_\_