



Name: _____ Exam Date: _____

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

Primary Care Physician: _____

How did you first hear about Orthopedic Foot and Ankle Institute?

Physician or other Health Professional: _____

Friend/Family Member: _____ Insurance Website Other _____

What concerns would you like addressed by your doctor today? _____

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

If so, describe the injury? _____

What bothers you most? Pain Swelling Falls Unstable Deformity Other _____

What distance can you walk before your symptoms begin?

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

Circle the number indicating your average pain due to your condition.

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Which activities make your symptoms worse?

Walking Running Uneven Ground Certain Shoes Getting up from a seated position

Which of the following have you tried?

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

Bracing Surgery

List any diagnostic studies (X-ray, 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 the year, starting with the most recent.

1. _____ 3. _____

2. _____ 4. _____

List all your current medications.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Allergies: None

1. _____ Reaction: _____ Severity: _____

2. _____ Reaction: _____ Severity: _____

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

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

Do you smoke? No Yes How much? _____ How long? _____

Do you drink alcohol? No Yes How often? _____ Do you use drugs? No Yes

Personal Medical History

Please circle all that apply:

- Anemia
- Gout
- Cancer
- Osteoporosis
- Mental Illness
- Seizures
- High Blood Pressure
- Phlebitis
- Alcoholism
- AIDS/HIV
- Fibromyalgia
- Chronic Back Pain
- Depression
- Diabetes
- Bleeding/bruising tendency
- Stroke
- Heart Condition
- Irregular Heart Beat
- Heart
- Asthma/Emphysema/Wheezing
- Pulmonary Embolism
- Blood Clots
- Sleep Apnea
- Kidney Transplant or Dialysis
- Rheumatoid Arthritis
- Stomach Ulcers

Review of Systems:

Please circle 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)
