

Foot & Ankle Patient Questionnaire

Date: _____

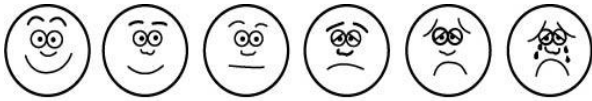
Name: _____ Birthdate: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Date that your pain started: _____ What are you being seen for? _____

Please circle your pain on a scale of 0-10

0 1 2 3 4 5 6 7 8 9 10



Face 0 Face 1-2 Face 3-4 Face 5-6 Face 7-8 Face 9-10

How were you injured? _____

Pain frequency: Constant Intermittent Occasional Rare

Pain Status: Changing Fluctuating Stable Worse Improving Resolved

Pain Quality: Aching Burning Dull Piercing Sharp Throbbing

Aggravated By: Bending Stairs (↑/↓) Lifting Movement Pushing Sitting
Standing Jumping Driving Walking/Running Other: _____

Relieved by: Brace/Splint Ice Mobility Stretching Elevation Injection

Exercise Massage Heat Rest Pain/RX/OTC Medication: _____

Symptoms: Bruising Limping Spasms Crepitus Locking Swelling ↓Mobility

Nocturnal Awakening Difficulty Initiating Sleep Nocturnal Pain Tingling (Toes / Legs)

Numbness Weakness Popping Joint Instability Joint Tenderness

Have you received care for this condition in the past? ☐ YES ☐ NO If yes by whom? _____

What treatment did you receive? _____

Medications: Please list all prescription and non-prescription medications, vitamins, birth control, herbs, inhalers etc.

Medications

☐ I take no medications

Allergies (include your type of reaction to this medication): _____

☐ I have no allergies

Height: _____

Weight: _____



Name: _____

DOB: _____

Past Medical History

Disease	Yes	No	Disease	Yes	No	Disease	Yes	No
Alzheimer's			Drug Abuse			Psoriasis		
Anemia Cause: _____ ☐ Unknown			Elevated Lipids Cause: _____ ☐ Unknown			Renal Disease Cause: _____ ☐ Unknown		
Alcoholism			Fibromyalgia			Scoliosis		
Arthritis ☐ Osteoarthritis ☐ Rheumatoid Other: _____			Gallbladder Disease			Seizure Disorder		
Asthma			Gout			Sleep apnea		
Anxiety			Headache/Migraine			Spinal Stenosis		
Cancer Type: _____ ☐ Unknown			Hepatitis/Liver Disease Type: _____ ☐ Unknown			Spondyloarthopathy		
Congestive Heart Failure			Hypertension (High Blood Pressure)			Stroke		
Coronary Artery Disease			IBS			Thyroid Disease		
Crohn's Disease			Myocardial Infarction (Heart Attack) ☐ Acute ☐ Recent ☐ Old			Valvular Disease		
COPD			Osteoporosis					
Diabetes ☐ Mellitus ☐ Gestational ☐ Type 1 ☐ Type 2			Parkinson Disease			Other: _____ ☐ AIDS/HIV ☐ Lyme Disease ☐ Blood Clot ☐ Multiple Sclerosis		
Depression			Peptic Ulcer Disease					

Surgical History

Surgical Procedure	Left / Right / Other	Year	Comments
Amputation			
Angioplasty			
Appendectomy			
Blood Transfusion			
Cardiac Pacemaker			
Cholecystectomy			
Hysterectomy ☐ Total ☐ Radical ☐ Vaginal			
Knee Replacement			
Mastectomy			
ORIF			
Rotator Cuff Repair			
Thyroidectomy			
Other:			

Name: _____

DOB: _____

Family History

Disease	Mother	Father	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other
Hypertension (High Blood Pressure)									
Diabetes M=Mellitus 1= type 1 2= Type 2									
Arthritis O= Osteoarthritis R= Rheumatoid									
Cancer Type: _____ ☐ Unknown									
Congestive Heart Disease									
Deceased									

Social History

Tobacco Use:

Smoke Cigarettes: ☐ Never ☐ No ☐ Yes Quit Date: _____ Years Smoked: _____

Current Smoker: Packs/Day: _____ How many years did you smoke? _____ Other: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use:

Do you drink Alcohol? ☐ No ☐ Yes # of drinks / week? _____ ☐ Beer ☐ Wine ☐ Liquor

Marital Status:

Single Married Divorced Widowed

Children:

☐ Yes ☐ No How Many? Boys: _____ Girls: _____

Occupation: _____

Hobbies: _____

Staff Use Only

Vitals: B/P: _____ Temp: _____ Pulse: _____ Resp: _____