

Date: _____

Age: _____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: _____ Estimated date first noticed problems: ____/____/____

Was this due to injury? Yes No Was injury work related? Yes No

Currently working? Yes No How did injury occur : _____

Prior surgery for this problem? Yes No If yes, list date, procedure and doctor _____

How would you rate your worst pain? 1 (No pain), 2, 3, 4, 5, 6, 7, 8, 9 and 10 (severe pain)

Problem is presently: Worsening Unchanged Improving

The pain is? Constant Intermittent

Location? Ankle _____ Lateral (outside) Medial (inside)
 Posterior (back) Anterior (front)

Foot Midfoot Forefoot (toes) Hindfoot (heel)

Quality? Sharp Dull Burning Throbbing
 Tingling Electric Shocks

Timing? Night Morning At Work During Exercise After Exercise

Activities which were interfered with include:

- Sports Walking Shopping Stair Climbing Waking or Sleeping
 Running Gardening Working Kneeling Squatting Rising from a chair
 Other _____

Treatments that have been tried include:

- Anti Inflammatory _____ Helped? Not Helped Physical Therapy Helped? Not Helped
 Pain Medications _____ Helped? Not Helped Crutches/Cane Helped? Not Helped
 Exercises Helped? Not Helped Injection Helped? Not Helped
 Reduced Activity Helped? Not Helped MRI
 Bracing Helped? Not Helped Other _____

Review of Systems: Please check all that apply for you

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thalassemia/Von Willebrands |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema/Chronic Bronchi | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Stomach Ulcer/Reflux |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ulcerative Colitis/Chron's |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Depression/Bipolar Disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Psoriasis or Skin Disease |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Seizure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma/Tuberculosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Adrenal/Pituitary Disease | <input type="checkbox"/> COPD |

- Diabetes, controlled with: Insulin Oral Medication Diet
 Cancer, which type/where? _____ Treatment _____
 None of the above _____ Other _____
 SECOND OPINION _____

Family History	Yes?	Relationship	Family History	Yes?	Relationship
Arthritis (Specify type)			High Blood Pressure		
Bleeding Problems			Congenital Heart Disease		
Cancer (Specify)			Leukemia		
Diabetes			Liver Disease		
Emotional Problems			Stroke		
Epilepsy/Seizures			Suicide		
Heart Disease			Tuberculosis		