

**Foot and Ankle Follow Up Form**

Name: \_\_\_\_\_ MRN: \_\_\_\_\_ Date: \_\_\_\_\_

1. Current Chief concern, if any: \_\_\_\_\_

2. What is your current pain score? (Please circle the number, or range of numbers, that describes your pain today)

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate				Severe		Worst pain imaginable

3. How would you rate your symptoms today compared to your last clinic appointment?  
 \_\_\_\_\_% better                      \_\_\_\_\_% worse                      No change                      N/A

4. Any change (decrease/increase) in the quality of your symptoms(i.e. redness, drainage, swelling, stiffness, instability, pain etc.) since your last visit? No Yes Explain: \_\_\_\_\_

5. What makes your symptoms better? \_\_\_\_\_

6. What is your current weight bearing status on the affected limb? None Touch Down Partial Full

7. What is your current immobilization method?  
Toe splint or brace Orthotic/Insoles Stiffsneaker/Post-op shoe Ankle brace Boot Splint Cast Other

8. What is your current assistive device? None Cane Crutches Walker Wheelchair

9. Have you participated in physical therapy?  No  Yes. If yes, dat(mo/year) of last session \_\_\_\_\_

10. Any recent illnesses, changes in your medical history, surgery, or hospitalizations since your lastvisit?  
No Yes, Explain: \_\_\_\_\_

11. Do you have diabetes? No Yes, if yes do you know your most recent hemoglobin A1C? \_\_\_\_\_

12. Do you have neuropathy or numbness in both feet?  No  Yes

13. Are you currently smoking, or using any form of nicotine/tobacco? No Yes  
 If yes, \_\_\_\_\_packs/day, other: \_\_\_\_\_

14. Do you take medication for chronic pain? No Yes. If yes, please list \_\_\_\_\_  
 \_\_\_\_\_

15. How many yards can you walk *without* stopping? \_\_\_\_\_ *With* stopping? \_\_\_\_\_

16. Circle all the following activities you are now able todo?  
Stand Walk Jog Run Drive Jump Climb Sports

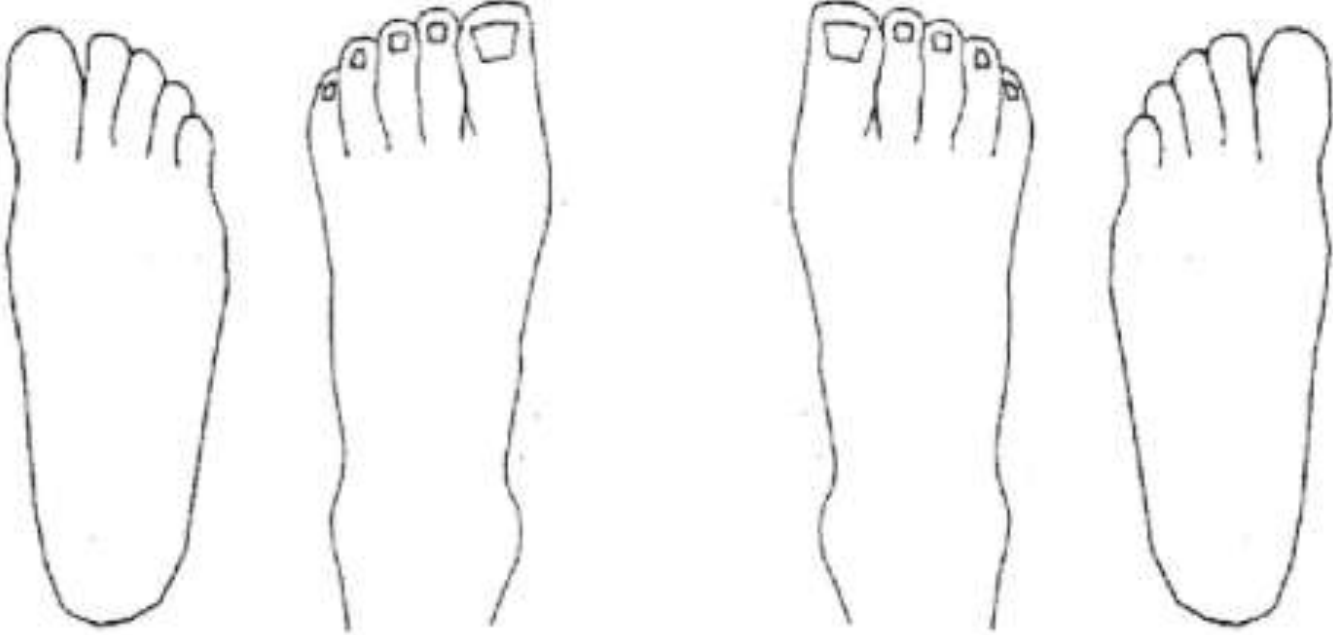
17. What is your current workstatus?  
Full duty Light duty Out of work Retired Permanently disabled

18. Where do you currently live? Home Rehab center Skilled nursing Other \_\_\_\_\_

Place Patient Label Here

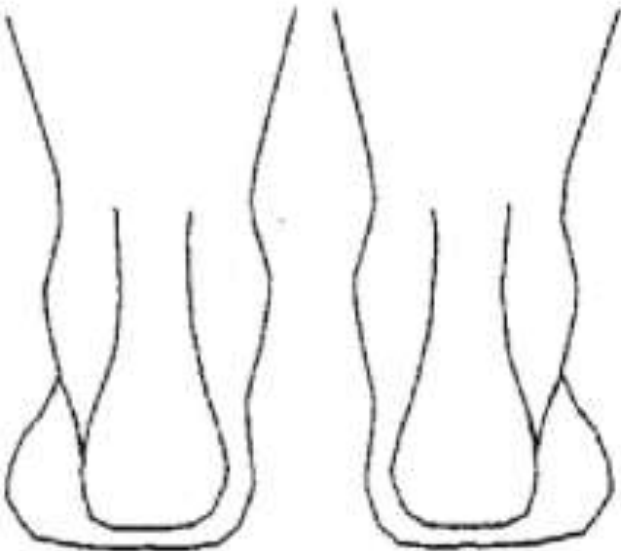
Please indicate with an (X) the location of your chief concern(s).

**Left foot** **Right foot**



**Sole / bottom** **Top** **Top** **Sole / bottom**

**Ankles (back view)**



**Left** **Right**

The form consists of several line drawings for medical assessment. At the top, there are two main sections: 'Left foot' and 'Right foot'. Each section contains two views: a 'Sole / bottom' view and a 'Top' view. The 'Top' views include small square boxes on each toe, intended for marking the location of a chief concern. Below these are two 'Ankles (back view)' diagrams, one for the 'Left' and one for the 'Right' ankle. Navigation icons (a close button 'X' on the left and back/forward arrows on the right) are located at the top of the form.