MRN #: ______________________

FOOT/ANKLE (New Patient/New Problem)

NAME___________________________________ AGE_________ SEX M / F DATE ____________________

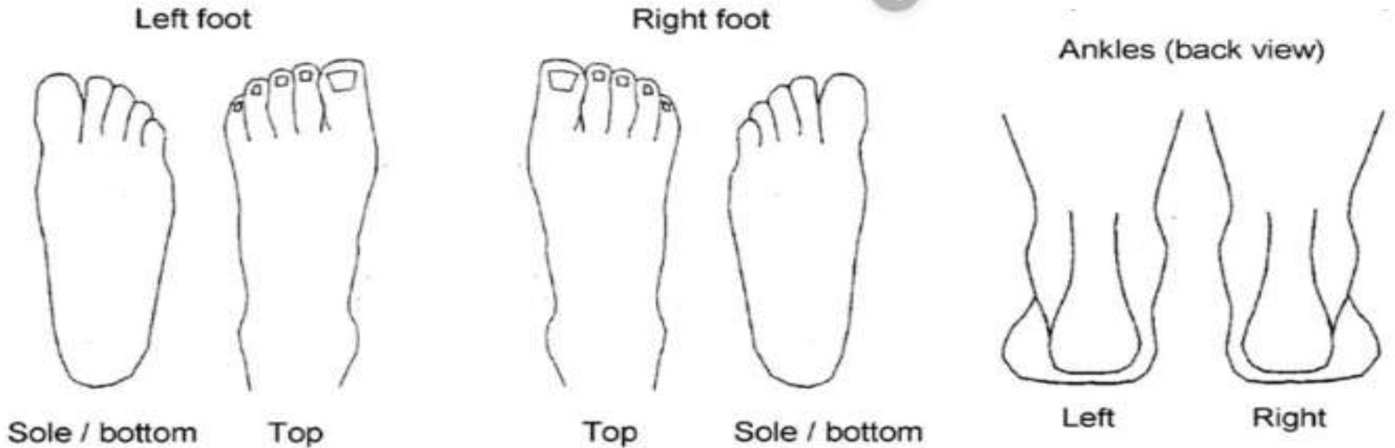
OCCUPATION/FORMEROCCUPATION: _______________________________________

IS THIS A WORK RELATED INJURY/WORKMAN'S COMPENSATION CLAIM: YES / NO

SIDE: LEFT /RIGHT /BOTH

LOCATION OFPAIN: FOOT/ANKLE / BOTH

(Be as specific as possible: place an **X** on the one spot of maximal tenderness, circle the areas of concern)



WHAT IS YOUR CURRENT PAIN? (Please circle the number/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

HOW FREQUENT IS YOUR PAIN? Occasional (monthly) intermittent (weekly) frequent (daily) Constant

WHAT TYPE OF PAIN DO YOU HAVE? Sharp Dull Aching Stabbing Electrical

DID YOU HAVE A SPECIFIC INJURY TO THE FOOT OR ANKLE? YES / NO **DATE**_________________________

IF YES PLEASE PROVIDE A SHORT DESCRIPTION OF THE INJURY____________________________________

____

WHAT MAKES YOUR SYMPTOMS BETTER? ____

____

WHAT MAKES IT WORSE? ____

____

MRN #: ________________________

HAVE YOU USED ANY OF THE FOLLOWING FOR YOUR SYMPTOMS?

☐ SteroidInjections Last injection (mo/year) _______________ Howmany injections total? ____________________________

☐ PhysicalTherapy Howmany weeks? __________________ When was your last session? (Mo/year)______________

☐ Anti-Inflammatory Medications (past & present - Aleve, Advil, Ibuprofen, etc)____

☐ Narcotic Pain Medication (past & present – Norco, Vicodin, Percocet, etc)____

☐ Previous Surgery on the foot and ankle (list below):

Surgery	Approximate Date	Surgeon and Facility

ANY INFECTION, SLOW WOUND HEALING, OR ANTIBIOTIC GIVEN AFTER THE ABOVE PROCEDURES?

YES / NO / Not applicable / other complications ____

DO YOU HAVE ANY OF THE MEDICAL CONDITIONS BELOW?

Diabetes Rheumatoid Arthritis Congestive Heart Failure

Lupus Other Autoimmune Disease History of Blood Clots (DVT/PE)

ARE YOU TAKING BLOOD THINNNERS? YES / NO **IF SO, WHAT TYPE?**

____

DO YOU HAVE NEUROPATHY OR NUMBNESS IN YOUR FEET? YES / NO

DO YOU HAVE OSTEOPOROSIS? YES / NO **IF YES, WHAT TREATMENTS?**

____

DO YOU SMOKE: YES / NO

If so, how much (packs/day)? ____________________________________

DO YOU REQUIRE ASSITIVE DEVICES?

None Cane at Times Cane Full Time Walker Wheelchair

HOW FAR CAN YOU WALK?

Unlimited 6Blocks 2-3Blocks Indoor Only Unable

CIRCLE ALL OF THE FOLLOWING ACTIVITIES YOU ARE ABLE TO DO RIGHT NOW?

Stand Walk Jog Run Drive Climb Sports

WHERE DO YOU CURRENTLY LIVE

Home Skilled Nursing Facility Acute Rehabilitation Center Assisted Living

DO YOU HAVE SUPPORT AT HOME? YES / NO **IF YES, FROM WHO?** ___________________________________