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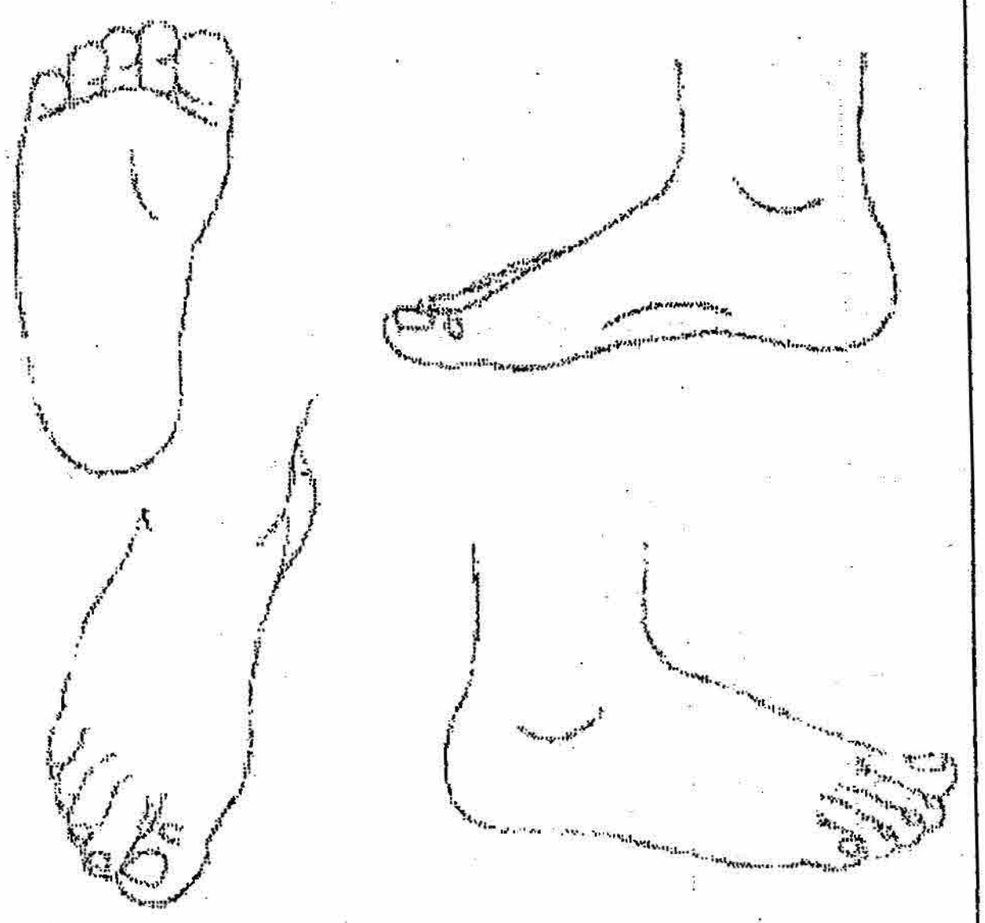
Patient Foot/Ankle Questionnaire

NAME_____ DATE_____

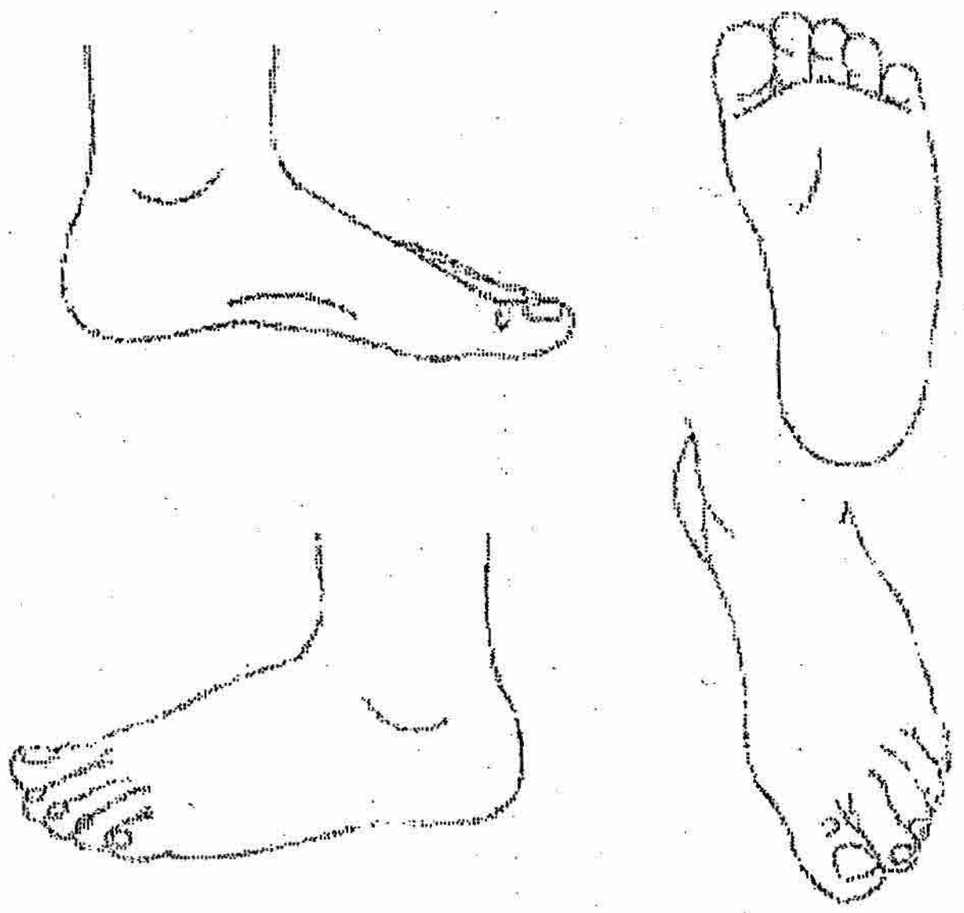
WHAT BRINGS YOU INTO THE OFFICE TODAY?			DESCRIBE YOUR PAIN	HOW MUCH OF THE DAY DO YOU STAND/WALK?
WAS THERE AN INJURY? YES NO	WHEN WAS YOUR INJURY?	WHEN DID IT START? *(if no injury)*	THERE IS NO PAIN ☐ ACHE ☐ DULL ☐ SHARP ☐ STABBING ☐ POUNDING ☐ THROBBING ☐	10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90-100% ☐
DOES THE PAIN OCCUR ONLY WITH CERTAIN ACTIVITIES? YES NO *(please explain)*				
WAS THERE A CHANGE IN ACTIVITY OR SHOES WHEN SYMPTOMS BEGAN? YES NO				

WHERE IS YOUR PAIN

RIGHT FOOT



LEFT FOOT



HAVE YOU NOTICED ANY:	DO YOU HAVE DIFFICULTY:	LIST PREVIOUS TREATMENTS:	WHAT MAKES IT FEEL BETTER:
REDNESS ☐ BRUISING ☐ SWELLING ☐ DISCOLORATION ☐ DRAINAGE/BLEEDING ☐	WALKING ☐ RUNNING ☐ CLIMBING ☐ SQUATTING ☐ WITH STAIRS ☐	CASTING ☐ BRACING ☐ STRAPPING ☐ CORTISONE SHOTS ☐ PHYSICAL THERAPY ☐	ICE ☐ REST ☐ ELEVATION ☐ ALEVE/ADVIL ☐ CERTAIN SHOES ☐
OTHER:_____	OTHER:_____	OTHER:_____	OTHER:_____

DO YOU USE CUSTOM ORTHOTICS YES NO	IF YES, HOW LONG HAVE YOU WORN THEM?	DO THEY HELP? YES NO
DO YOU EXERCISE REGULARLY? YES NO	WHAT KIND OF EXERCISE DO YOU DO?	HOW OFTEN DO YOU EXERCISE?
DO YOU HAVE ANY OTHER PERTINENT THINGS TO MENTION ABOUT THIS PROBLEM?		

BIRTHDAY:_____ HEIGHT:_____WEIGHT_____

RACE: WHITE BLACK HISPANIC ORIENTAL OTHER

PAST MEDICAL HISTORY

	Yes	No		Yes	No
ARTHRITIS	❑	❑	DIABETES	❑	❑
ARTIFICIAL JOINTS	❑	❑	HEPATITIS A / B / C	❑	❑
ASTHMA/BRONCHITIS/COPD	❑	❑	HIGH BLOOD PRESSURE	❑	❑
BLEEDING ABNORMALITIES	❑	❑	POOR CIRCULATION	❑	❑
BACK PROBLEMS	❑	❑	PSYCHIATRIC/PSYCHOLOGICAL CARE	❑	❑
HEART DISEASE	❑	❑	BLOOD CLOTS	❑	❑
HEART ATTACK OR STROKE	❑	❑	THYROID DISEASE	❑	❑
HIV INFECTION	❑	❑	Other:		

MEDICATIONS

MEDICATION	MILLIGRAMS	INDICATION	MEDICATION	MILLIGRAMS	INDICATION
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

ALLERGIES

NONE THAT I KNOW OF ❑

	Yes	No
PENICILLIN	❑	❑
NSAIDS/ASPIRIN	❑	❑
SULFA DRUGS	❑	❑
LOCAL ANESTHETICS	❑	❑
ADHESIVE TAPE	❑	❑
IODINE ON SKIN	❑	❑

Other: _____

SOCIAL HISTORY

OCCUPATION

MARITAL STATUS

S M D W

DO YOU SMOKE? *(Cirle One)*

YES NO

DO YOU DRINK ALCOHOL? *(Circle One)*

YES NO

HOW MANY PACKS PER DAY?

(circle one if you answered yes above)

DAILY

OCCASIONALLY

SOCIALLY

HOW MANY YEARS HAVE YOU SMOKED?

REVIEW OF SYSTEMS

	Yes	No
FEVERS	❑	❑
CHILLS	❑	❑
NAUSEA	❑	❑
VOMITING	❑	❑
TINGLING IN FOOT	❑	❑
BURNING IN FOOT	❑	❑
ITCHING	❑	❑
RASH	❑	❑

FAMILY HISTORY

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING CONDITIONS?

	Yes	No
DIABETES	❑	❑
HEART DISEASE	❑	❑
STROKE	❑	❑
HIGH BLOOD PRESSURE	❑	❑
CANCER	❑	❑

Other: _____

LIST ALL THE SURGERIES YOU HAVE HAD

1.	4.
2.	5.
3.	6.

STOP!!!

PLEASE DO NOT WRITE ON THE FOLLOWING PAGES