Patient Foot/Ankle Questionnaire

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NAME_____ DATE_____

WHAT BRINGS YOU INTO THE OFFICE TODAY?

WAS THERE AN INJURY?	WHEN WAS YOUR INJURY?	WHEN DID IT START? *(if no injury)*
YES NO		

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

DESCRIBE YOUR PAIN

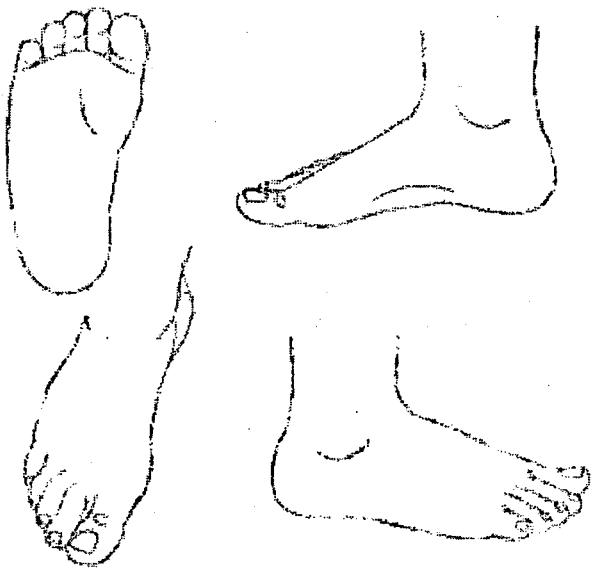
- THERE IS NO PAIN ☐
- ACHE ☐
- DULL ☐
- SHARP ☐
- STABBING ☐
- POUNDING ☐
- THROBBING ☐

HOW MUCH OF THE DAY DO YOU STAND/WALK?

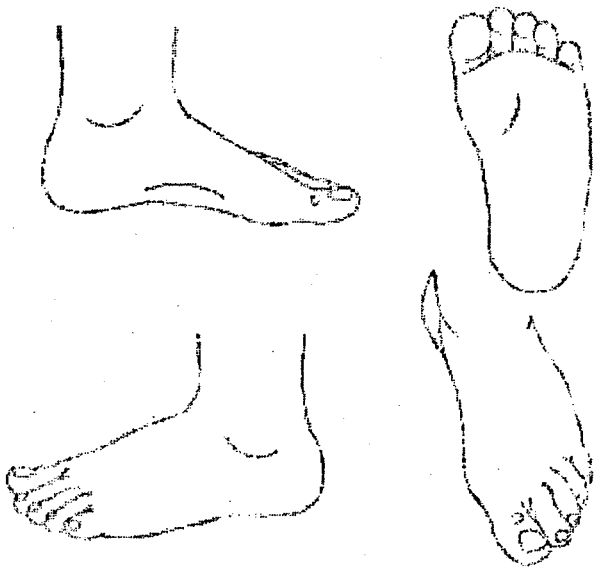
- 10-20% ☐
- 30-40% ☐
- 50-60% ☐
- 70-80% ☐
- 90-100% ☐

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 ☐	WALKING ☐	CASTING ☐	ICE ☐
BRUISING ☐	RUNNING ☐	BRACING ☐	REST ☐
SWELLING ☐	CLIMBING ☐	STRAPPING ☐	ELEVATION ☐
DISCOLORATION ☐	SQUATTING ☐	CORTISONE SHOTS ☐	ALEVE/ADVIL ☐
DRAINAGE/BLEEDING ☐	WITH STAIRS ☐	PHYSICAL THERAPY ☐	CERTAIN SHOES ☐
OTHER:_____	OTHER:_____	OTHER:_____	OTHER:_____

DO YOU USE CUSTOM ORTHOTICS	IF YES, HOW LONG HAVE YOU WORN THEM?	DO THEY HELP?
YES NO		YES NO
DO YOU EXERCISE REGULARLY?	**WHAT KIND OF EXERCISE DO YOU DO?**	**HOW OFTEN DO YOU EXERCISE?**
YES NO		

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?

HOW MANY YEARS HAVE YOU SMOKED?

(circle one if you answered yes above)

DAILY

OCCASIONALLY

SOCIALLY

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