Patient Name:___________________________________ Date of Birth:_______________Today's Date:__________________
What is your specific foot/ankle problem? ____
When did the problem begin? ____
Which foot/ankle is involved? ☐Right ☐Left ☐Both
What improves the problem? ____
What aggravates the problem? ____
Rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)
Describe previous treatments: ____
Is this from an injury? ☐Yes ☐No If so, is it work-related? ☐Yes ☐No
Primary Care Physician Name: ______________________________ Date Last Seen: ____________ Phone #: ______________
Height______Weight________ Shoe Size_______

PAST MEDICAL HISTORY:

☐ Diabetes Type 1 2 Duration_____Years Last Blood Sugar: ____ HgA1C: ____

☐ Acid Reflux/Stomach Ulcers
☐ Anesthesia complications
☐ Arthritis
☐ Asthma
☐ Back problems/Sciatica
☐ Blood clot/DVT
☐ Cancer: ____________________
☐ Cellulitis/Skin Infections-MRSA
☐ Fibromyalgia
☐ Foot/Leg Ulcer
☐ Gout
☐ Healing Problems/Keloids
☐ Heart disease/Heart Attack
☐ High Blood Pressure (Low BP?)

☐ Immune Disorder/HIV
☐ Kidney Disease (Dialysis)
☐ Liver Disease (Hepatitis)
☐ Leg Cramps/Leg Pain At Rest
☐ Lung Condition: _____________
☐ Mitral Valve Prolapse/Murmur
☐ Multiple Sclerosis
☐ Nervous Disorder/Depression
☐ Neuropathy/Chronic Regional Pain Syndrome
☐ Osteomyelitis/Bone Infection
☐ Raynaud's Disease/Phenomena
☐ Rashes/Skin Condition
☐ Seizure Disorder/Epilepsy

☐ Sleep Apnea
☐ Stroke ☐Right ☐Left
☐ Varicose Veins
☐ Parkinson's Disorder
☐ Pulmonary Embolism
☐ Women-Are you pregnant or breastfeeding?
☐ Previous Addiction To: ______________________________
☐ Other Problems Not Listed: ______________________________

PAST SURGERIES:

☐ Foot/Ankle Surgery: _____________________
☐ Joint Replacement: ________________________
☐ Open Heart/Bypass Surgery
☐ Stent Placement: Heart Lung
☐ Vascular Leg Bypass/Open Fracture Repair
☐ Carotid Surgery/Vein Surgery

MEDICATIONS:____
____
____
____

ALLERGIES: ☐None List:____

SOCIAL HISTORY:
Occupation: ___________________________
I Stand _______% of My Day
I Exercise Each Week: 0 Days/ 1-2 Days/ 3+ Days
List Sports/Activities:___________________________
____

I drink alcoholic beverages: ☐ Y ☐ N
How much/often?______________________________
I use or have used tobacco products Type: __________ Packs/Day: ____ Years: _______ When Stopped: ______
I use or have used drugs that are illegal: ☐ Y ☐ N