Date __/__/____       Name ______________________________________________________

1. What is the foot and/or ankle problem for which you are seeing the doctor today?

2. Do you have pain in your foot/ankle? □ Yes □ No
   If yes, please check one box indicating your average pain level on a day-to-day basis.
   □ mild, occasional □ moderate, daily □ severe, almost always present
3. Please mark on the diagram below the location of your typical pain.

XXX = aching       | | | = sharp, stabbing        ^^^ = burning           OOO = other

4. Please draw a slash (e.g.______) on the line below indicating the average daily pain you feel, from 0 to 10.

5. What makes your pain worse?

6. What makes your pain better?

7. With respect to your function (i.e. day-to-day and/or recreational activities), do you have:
   □ No limitations □ Limited daily and recreational activities
   □ No day-to-day limitations, limited recreation □ Severe limitation of daily and recreational activities

8. What, if any, walking aids do you typically use:
   □ None □ Any shoe, no insert required
   □ Cane □ Comfort shoes only, +/- an insert (orthotic)
   □ Walker, crutches, wheelchair □ Modified shoes or a brace

9. With respect to footwear, do you typically use:
   □ None □ Any shoe, no insert required
   □ Cane □ Comfort shoes only, +/- an insert (orthotic)
   □ Walker, crutches, wheelchair □ Modified shoes or a brace

10. How far can you walk before you have to stop?
    □ Greater than 6 city blocks □ No difficulty on any surface
    □ Between 4 and 6 city blocks □ Some difficulty on uneven terrain, stairs, or inclines
    □ Between 1 and 3 city blocks □ Severe difficulty on uneven terrain, stairs, or inclines
    □ Less than 1 block

11. With respect to walking surfaces, do you have:

12. What treatment has been tried so far for your problem (i.e. braces, shoe inserts, surgery, etc.)
13. Please check the appropriate box below indicating any past medical problems:

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other heart problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other problem (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. List any operations you have had in the table below:

<table>
<thead>
<tr>
<th>Type of operation</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. List any current medications in the table below:

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Drug name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list any additional medications on the back of this page, if necessary.

16. Do you have any allergies to medications? □ Yes □ No. If yes, please list below:

17. Do you have a family history of foot problems? (parents, grandparents, siblings) □ Yes □ No

18. Are you a smoker? □ Never □ Past (when?): ____________ □ Currently – amount per day ____________

19. What is your current living situation?

- □ Alone
- □ Roommate(s)
- □ Spouse
- □ Family
- □ Parents

20. What is your current accommodations:

- □ House
- □ Apartment
- □ Other: ____________

Do you have stairs? □ Yes, how many □ No

21. What best describes your employment situation:

- □ Presently employed as: ____________
- □ Unemployed, previously employed as: ____________
- □ Retired, previously employed as: ____________
- □ Student attending: ____________
- □ On disability for: ____________

Other, please specify: ____________

22. Are receiving, or do you expect to receive compensation for this medical problem? (i.e. worker’s comp, lawsuit, auto accident, etc.) □ Yes □ No

If yes, please explain: ____________
## Constitution
**YES NO HOW LONG?**
- Fever or Chills (circle which one)
- Easily fatigued
- Unexplained weight loss/gain
- Unexplained decreased appetite
- Nausea or Vomiting

## Cardiovascular
**YES NO HOW LONG?**
- Chest pain or Angina
- Heart murmur
- Irregular heart rate
- Poor circulation
- Leg/ankle swelling

## Allergy/Immunology
**YES NO HOW LONG?**
- When exposed to allergens, do you get:
  - Sneezing, runny nose or itching eyes
  - Hives or itchy rash
  - Difficulty breathing or swallowing
  - Are you allergic to metals?
  - Do you get sick or get infections frequently?

## Neurological
**YES NO HOW LONG?**
- Seizures or Tremor
- Frequent headaches/migraines
- Feeling faint or dizzy
- Numbness or loss of sensation
- Tingling or pain that radiates

## Hematologic/Lymphatic
**YES NO HOW LONG?**
- Previous Deep Vein Thrombosis
- Bleeding problems
- Easy bruising
- Enlarged lymph nodes (neck / arm pit / groin)

## Gastrointestinal
**YES NO HOW LONG?**
- Diarrhea or Constipation
- Leakage of bowel
- Bloody stool

## Ears, Nose, Mouth, Throat
**YES NO HOW LONG?**
- Loss of hearing
- Nasal problems
- Toothache/Bleeding gums/Sores
- Difficulty swallowing

## Musculoskeletal
**YES NO HOW LONG?**
- Difficulty moving any limb
- Muscle wasting or weakness
- Swelling, Where?
- One limb smaller/larger than the other

## Respiratory
**YES NO HOW LONG?**
- Shortness of breath
- Cough
- Coughing up blood
- Do you have a cold?

## Genitourinary
**YES NO HOW LONG?**
- Pain when you urinate
- Frequent urination
- Unable to control urination
- Blood in urine

## Skin
**YES NO HOW LONG?**
- Rashes or Sores that don’t heal
- Lesions changing in size, shape or color

## Eyes
**YES NO HOW LONG?**
- Recent change of vision
- Other eye problem

## Endocrine
**YES NO HOW LONG?**
- Excessive thirst or hunger
- Cold or heat intolerance
- Night sweats

---

When did your pain start?

What is the quality of your pain? (aching, burning, numbness, pins & needles, stabbing, other):

What makes your pain better? (rest, ice, heat, massage, medications):

What makes your pain worse? (activity, walking, running, bending, squatting):

How many hours a day do you have this pain?

---

Reviewed by: ____________________________ Date: ______________

Provider’s Signature

Printed Name