New Patient – History of Foot & Ankle Complaint
(One form for each problem)

Patient Name: ________________________________

• How is your overall health?  Excellent  Very Good  Good  Fair  Poor

• Where is your complaint located?

• When did your complaint first begin?

• Is your complaint painful?  Yes  No

• If painful, how would you describe the pain?
  o  Sharp  Dull  Burning  Throbbing  Aching  Numbness

• How would you grade the severity of your pain?
  o  No pain  Mild  Moderate  Severe

• How would describe the onset of your complaint?
  o  Sudden  Gradual

• Is your complaint constant or intermittent (comes and goes)?
  o  Constant  Intermittent

• What makes the complaint better?

• What makes the complaint worse?

• Does strenuous activity make your complaint worse?  Yes  No

• Have you noticed a change in weight associated with the onset of the complaint?  Yes  No

• Did an injury cause your complaint?  Yes  No
  If yes, please explain:

• Is an increase in activity associated with the timing of your complaint?  Yes  No

• Has the complaint interfered with your ability to perform daily activities?  Yes  No

• Is a fever associated with your complaint?  Yes  No

• Self Treatment – on your own, what medications, devices or other things have you done to treat your complaint?

• Is there a type of shoe that makes your complaint better?  Yes  No
  o  (If yes, what type?)
• What type of shoe do you most commonly wear?

• What best describes the current treatment for your complaint?
  o Currently not receiving treatment
  o Received treatment that did not help
  o Received treatment that did help

• Professional Treatment – have you been treated by another provider for your complaint?
  o Yes  No  (If yes, who and what did they do?)

• Have you had any radiologic exams related to your complaint?
  o X-ray  CT scan  MRI  Ultrasound  Bone scan

• Has anyone in your immediate family had the same complaint?  Yes  No

• Has anyone in your immediate family been treated for the same complaint?  Yes  No

• Do you feel that your complaint is affecting you emotionally?  Yes  No

________________________________________
Patient Signature  Date