Date: _____

Initial Comprehensive Foot & Ankle Questionnaire

Please complete this form before your first appointment at the Reconstructive Foot & Ankle Institute, LLC. Your careful answers will help us to understand your foot and ankle problem and design the best treatment plan for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g. Workmen's Compensation Claims).

Name: _____ **Age**: _____

Height: _____ Weight: _____ Shoe Size: _____

Family Physician: _____

How did you hear about our office? _____

Describe your foot or ankle problem: ❑Right ❑Left _____
_____

Describe any treatment you have tried for your problem (including any treatment from previous doctors):_____
_____

Where is your pain? (Check all that apply)
- ❑ Heel/Arch Pain
- ❑ Ankle pain (outside, inside, front, back of ankle)
- ❑ Foot pain (top, bottom)
- ❑ Toe Problem (big toe, 2nd, 3rd, 4th, 5th)

How long have you had your current problem? _____Years _____Months

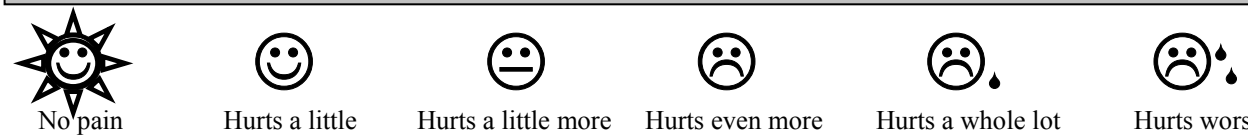
Onset of problem: How did your current problem start?

Injury at work	Illness, non-injury
Injury, not at work	Treatment caused (e.g. radiation, surgery, etc)
Motor vehicle accident	Undetermined

If there was a precipitating event not mentioned, what was it? _____

How much pain do you have? What is the severity?

Pain Rating Scale (please circle one)



No pain	Hurts a little	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts worst
0	1-2-3	4-5	6-7	8-9	10

Timing of problem / pain: How often do you have your pain? (check one)

Constantly (100% of the time)	Intermittently (30-60% of the time)
Occasionally (less than 30% of the time)	Nearly constantly (60-95% of the time)

In general, during the past month, when has your pain/problem been the worst? (check one)

Morning Night Afternoon Evening No typical pattern

Symptom quality: How would you describe your pain?
(Check all that apply and circle the dominant quality)

Burning	Sharp	Cutting	Throbbing	Electric
Cramping	Dull/aching	Pressure-like	Shooting	Pins and needles
Walking on a pebble		Pain on first step of day		Other (describe) _____

Relieving and aggravating factors:

How does the following affect your pain? (check one for each activity)

Activity	Decrease	No Change	Increase
Standing			
Sitting			
Walking			
Exercise			
Elevation			

Check all that apply.
Aggravated by: Weather ___ Shoe ___ Touch ___
Relieved by: Heat ___ Cold ___ Rest ___ Meds ___ Ace or compressive wrap ___

Activities and your pain:

How many blocks can you walk? Less than a block or How many blocks?_____

To assist walking, I use a: Cane Walker Wheelchair No assistance device

Are you **NOT** able to perform any of the following activities of daily living? (Check all that apply)

Going to work | Performing household chores | Doing yard work or shopping
Wearing shoes | Participating in recreational activities | Exercising

Past personal & family medical history:

Have you or a family member had any of the following health problems?

	YES	NO	FM HX		YES	NO	FM HX
Alcoholism				Heart Condition			
Anemia				Heart Valve Issues			
Angina/ Chest Pain				High Blood Pressure			
Asthma				High Cholesterol			
Bleeding Disorder				Infection Prone			
Blood Clots (DVT)				Kidney Condition			
Blood Thinner				Liver Condition			
Bone Fracture				Menopause			
Cancer				Obesity			
Depression				Osteomyelitis			
Diabetes				Parkinson Disease			
Emphysema				Raynauds			
Epilepsy / Seizures				Rheumatic Fever			
Fainting				Rheumatoid Arthritis			
Fibromyalgia				Sickle Cell			
Foot Disorder				Thyroid Condition			
Foot Surgery				Tuberculosis			
G.I. Condition				Ulcer			
Gout				Vascular Disease			
Heart Attack /Stroke				Vascular Necrosis			

Please list any other condition(s) _____

If you have <u>diabetes</u> please answer the following questions:

How long have you had diabetes? _____Years _____Months
What is your usual blood sugar level by finger stick? _____
How many times a day do you check your finger stick blood sugar? _____

Past surgical history: Please list any hospitalizations/surgeries with approximate dates**.**

Surgeries/ Injuries	Date	Surgeries/ Injuries	Date
Abdominal surgery		CABG (heart bypass)	
Amputation		Cardiac Surgery	
Angioplasty		Cancer Surgery	
Ankle surgery		Cataract Surgery	
Appendectomy		Cholecystectomy	
Artificial joint		Cosmetic Surgery	
Back surgery		**Foot Surgery**	
Biopsy		GYN Surgery	
Bowel surgery		Vascular Surgery	

List other surgeries:_____

Allergies: What allergies do you have?

	Reaction		Reaction
Aspirin		Ampicillin	
Codeine		Tylenol	
Iodine (Seafood)		Eggs	
Novocain		NSAIDS	
Penicillin or other antibiotics		Latex	
Tape		Glove Powder	
Sulfa drugs		Demerol	
Cortisone		Morphine	
Other		Other	

List any other allergies: _____

Current medications:

Name of Medication	Dose	Frequency

Social history:

Education: Your highest education level achieved:

Graduate or professional training
College graduate
Partial college training
High school graduate
GED or trade-technical school graduate
Partial high school (10th grade through partial 12th grade)
Partial junior high school (7th grade through 9th grade)
Elementary school

Employment: Your current or most recent occupation:

Semi-skilled or unskilled (eg. Waitress, assembler)
Skilled trade or clerical (eg. Carpenter, electrician, truck driver, secretary)
Business executive or Managerial
Professional (eg. Lawyer, teacher, nurse, physician)
Homemaker
Other: please specify _____

Current employment status: (Check one)

Employed full time	Retired
Employed part time	Student
Unemployed	Homemaker

If you are unemployed or employed part time, is this due to your present foot condition? Yes No
If you are currently unemployed, indicate how long you have been off work: _____

Family life: (Please specify living arrangements)

Living alone	Living with children	Living with parents
Living with spouse/partner	Living with friends	
Living with spouse/partner and children	Living with other	

Substance abuse:

Have you ever been a smoker? Yes-Current Yes In-past No-Never
If you smoke, how many packs per day? _____ Packs per day
For how many years did you smoke? _____ Years
Do you have a history of alcoholism? Yes No Current problem
Have you abused prescription analgesics? Yes No Current problem
Cocaine or intravenous substance abuse? Yes No Current problem
How many years has it been since you abused alcohol or drugs? _____ Years

Review of systems: Please circle yes or no if you have any of the following problems:

Constitutional		
Good general health	Yes	No
Recent Weight changes	Yes	No
Night sweats, Fevers	Yes	No
Fatigue	Yes	No
Eyes		
Wear glasses/ contacts	Yes	No
Blurred/ double vision	Yes	No
Eye disease or injury	Yes	No
Glaucoma	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Heart Trouble	Yes	No
Swelling hands/feet	Yes	No
Musculoskeletal		
Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No
Integumetary (Skin/Breast)		
Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain or discharge	Yes	No
Endocrine		
Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Hormone problem	Yes	No
Genitourinary – Male Only		
Blood in Urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Testicle pain	Yes	No
Psychiatric		
Insomnia	Yes	No
Confusion/ Memory loss	Yes	No
Depression	Yes	No

Ears/Nose/Throat/Mouth		
Hearing loss or ringing	Yes	No
Sinus Problems	Yes	No
Nose Bleeds	Yes	No
Sore throat/ voice change	Yes	No
Gastrointestinal		
Nausea/ vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No
Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/ asthma	Yes	No
Coughing up blood	Yes	No
Neurological		
Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Convulsions/ seizures	Yes	No
Numbness/ tingling	Yes	No
Allergic/ Immunologic		
Food allergies	Yes	No
Aspirin allergies	Yes	No
Antibiotic allergies	Yes	No
Hematologic/ Lymphatic		
Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
Genitourinary – Female Only		
Blood in Urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Menstrual problems	Yes	No

Other

_____
_____
_____

PHYSICAL EXAMINATION: **TO BE COMPLETED BY PHYSCIAN**
Not to be filled out by patient.

Temp: _____ Pulse: _____ Blood Pressure: _____ Respirations: _____

Neurological:
Gait/Stance: Normal Antalgic Pronated
Higher intelligence: Intact CN II-XII intact
SW5.07MF _____ out of 10 Left/Right
Protective Sensation intact to _____ level

Vibratory	left	right
Light touch	left	right
Sharp dull	left	right
Tinnel's sign	left	right
Sub Abd pain	left	right
Achilles	left	right
Patellar	left	right
Babinski	left	right
Clonus	left	right

Lymphatic:
Swelling leg left right
Palpable Lymph Nodes leg ankle foot

Vascular:

DP	left	right
PT	left	right
POP	left	right
CAP Fill <3	left	right
CAP Fill >3	left	right
Hair	left	right
Skin Temp	left	right

Dermatologic:
Nails Normal Dystrophic
Hyperkeratosis _____
Wound_____
Width _____ Depth: _____
Base: _____ Length: _____
Rash _____

Musculoskeletal:

Equipment:

Crutches	Cane	Heel Cup
Ankle Corset	Custom shoes	Orthotics
Cam Walker	Wheelchair	Walker
Extra-depth shoes	Other _____	

Toes_____
Metatarsals _____
RF Alignment_____
Bunion_____
Fracture _____
Muscle Strength _____/5
Other_____

Data: (e.g. CT, MRI, X-ray, Laboratory, Ultrasound)

_____

Assessment/Plan
1.

2.

3.

4.