



# Initial Patient History

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Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Today's visit is for:  Foot  Ankle  L  R  Both

Please describe your current foot and ankle complaints:

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When did it start and how?

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What makes it feel better?

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What makes it feel worse?

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Have you seen an orthopedist for this?  Yes  No If yes, Dr.'s name \_\_\_\_\_

Have you seen a podiatrist for this?  Yes  No If yes, Dr.'s name \_\_\_\_\_

What treatment has been tried?

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Hard Orthotics | <input type="checkbox"/> Change in exercise program | <input type="checkbox"/> Cast         |
| <input type="checkbox"/> Soft Orthotics | <input type="checkbox"/> Physical Therapy           | <input type="checkbox"/> Walking Boot |
| <input type="checkbox"/> Shoe Inserts   | <input type="checkbox"/> Cortisone Injections       |                                       |

What tests have you had for this?

- |  |                                    |  |
|--|------------------------------------|--|
| <input type="checkbox"/> X-rays (lying down) | <input type="checkbox"/> MRI       | <input type="checkbox"/> Nerve Study                 |
| <input type="checkbox"/> X-rays (standing)   | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Vascular/Blood Flow Studies |
| <input type="checkbox"/> CT Scan             |                                    |  |

Medications: (for this problem ONLY please)

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Surgery: (Lower extremity and back ONLY please, with approximate date.)

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What kind of exercise/sports do you do? (Please include distance or time and times per week.)

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