

HISTORY OF FOOT OR ANKLE PROBLEMS

Patient Name: _____ **Date:** _____

Primary Care Physician: _____

Date of last visit with Primary (approximate): _____

1. Onset: Please circle

When did the pain start? eg: 1 week, 1 month, 1 year, other _____

2. Nature of Pain: Please circle

What kind of pain or pains are you having? eg: sharp, dull, shooting, stabbing, aching, radiating, diffuse, constant, intermittent, other _____

3. Location: Please circle

Where is the pain? eg: right or left foot, ankle, toes, top or bottom of foot, arch, heel, ankle, toenails, shins, other _____

4. Symptoms: Please circle

Do you have? eg: swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping, other _____

5. Severity of Pain: Please circle Constant or intermittent

Scale of 1 thru 10, 1 being no pain , 10 being severe pain

Please circle 1 2 3 4 5 6 7 8 9 10

6. Past Treatment:

Self: What have you done to alleviate pain? (rest, ice, medication, change activities, change shoes)

Professional: Have you seen anyone for this problem? What did they do for you?

What advice or treatment was given?

7. Footwear: Please circle

What shoes can you wear? eg: tennis shoes, heels, boots

What shoes do you avoid and why? eg: tennis shoes, boots, heels

8. Work/Recreation

How has this affected your work ?

9. How has this affected your recreational activities? eg: stopped running, skiing, walking, etc

Patient Signature/Date