# GENERAL FOOT AND ANKLE HISTORY



**NAME:**_____ Age:_____ Date:_____
**XRAYS:** I have brought in xrays today. Yes_____ No_____

**REFERRING PARTY: (please give name)**
Physician_____ Phone(____) _____ FAX(____) _____
Address_____
City_____ State_____ Zip_____
Friend_____
Family Member_____
Other_____
**PERSONAL PHYSICIAN**_____ Phone(____) _____ FAX(____) _____
Address_____
City_____ State_____ Zip_____
Date of last visit_____

**PRESENT GOAL IN SEEKING EVALUATION: Check one or more.**
Correction of deformity and improvement of appearance_____
Relief of pain_____ Second Opinion_____ Other_____

**MAIN PROBLEM: Check one or more.**
Pain or aching____ Swelling____ Weakness____ Stiffness____ Deformity____ Lump____
Instability or giving out___ Other_____

**LOCATION & DURATION OF MAIN PROBLEM: Check one or more. Number according to severity.**

| **PROBLEM:** | | **DURATION of SYMPTOMS:** | **or** | **DATE OF ONSET** |
|---|---|---|---|---|
| Leg: | R__L__ | __weeks __months ___years | | _____ |
| Ankle: | R__L__ | __weeks __months ___years | | _____ |
| Heel: | R__L__ | __weeks __months ___years | | _____ |
| Bunion: | R__L__ | __weeks __months ___years | | _____ |
| Top of Arch: | R__L__ | __weeks __months ___years | | _____ |
| Sole of Arch: | R__L__ | __weeks __months ___years | | _____ |
| Ball of Foot: | R__L__ | __weeks __months ___years | | _____ |
| Great toe: | R__L__ | __weeks __months ___years | | _____ |
| 2nd toe: | R__L__ | __weeks __months ___years | | _____ |
| 3rd toe: | R__L__ | __weeks __months ___years | | _____ |
| 4th toe: | R__L__ | __weeks __months ___years | | _____ |
| 5th toe: | R__L__ | __weeks __months ___years | | _____ |

**BREIFLY DRAW LOCATION OF MAIN PROBLEM ON THE DIAGRAM ON THE NEXT PAGE.**

**DESCRIPTION OF ONSET: Check one or more.**
Congenital____ Crush____ Repetitive use____ Sudden onset____ Work related____
Fall____ Twist____ Direct Blow____ Gradual onset____ Sports related____
Other_____
Specify your location (home, work etc.) and briefly describe what happened when symptoms started.
_____
_____
_____
_____
_____
Office use only _____
_____

**PREVIOUS TREATMENT: NONE_____(If none, skip to SELF CARE)**

**1. FIRST doctor I saw for this problem:**

Name_____City_____
Emergency Room Doctor_____ Podiatrist_____ Company doctor_____ Family doctor_____
Orthopaedic surgeon _____ Other_____
Date of First Exam_____Date of last visit_____
**TESTS:** xrays_____ blood tests_____ nerve tests_____ CT scan_____ bone scan_____MRI_____
**TREATMENT:**

| | | | |
|---|---|---|---|
| steroid injections_____how many_____date of last one_____ | Helped? | Yes____ | No____ |
| anti-inflammatory pills____drug names_____ | Helped? | Yes____ | No____ |
| pain pills_____ drug names_____ | Helped? | Yes____ | No____ |
| physical therapy_____ type_____ | Helped? | Yes____ | No____ |
| pads/shoe modifications_____ | Helped? | Yes____ | No____ |
| orthotics_____ | Helped? | Yes____ | No____ |
| cast_____how long?_____ | Helped? | Yes____ | No____ |
| surgery_____(only recommended surgery did not do_____) | Helped? | Yes____ | No____ |
| other_____ | Helped? | Yes____ | No____ |

**2. SECOND doctor I saw for this problem:**

Name_____City_____
Emergency Room Doctor_____ Podiatrist_____ Company doctor_____ Family doctor_____
Orthopaedic surgeon _____ Other_____
Date of First Exam_____Date of last visit_____
**TESTS:** xrays_____ blood tests_____ nerve tests_____ CT scan_____ bone scan_____MRI_____
**TREATMENT:**

| | | | |
|---|---|---|---|
| steroid injections_____how many_____date of last one_____ | Helped? | Yes____ | No____ |
| anti-inflammatory pills____drug names_____ | Helped? | Yes____ | No____ |
| pain pills_____ drug names_____ | Helped? | Yes____ | No____ |
| physical therapy_____ type_____ | Helped? | Yes____ | No____ |
| pads/shoe modifications_____ | Helped? | Yes____ | No____ |
| orthotics_____ | Helped? | Yes____ | No____ |
| cast_____how long?_____ | Helped? | Yes____ | No____ |
| surgery_____(only recommended surgery did not do_____) | Helped? | Yes____ | No____ |
| other_____ | Helped? | Yes____ | No____ |

**IF YOU SAW MORE THAN TWO DOCTORS FOR THIS PROBLEM PLEASE CHECK AND DESCRIBE TESTS AND TREATMENT ON THE BACK SIDE OF THIS PAGE. ____**

**FOOT AND ANKLE SURGEY: list earliest surgery first. NONE_____**

1. Date_____Doctor_____Hospital_____
   Type of surgery_____
   Helped? Yes_____No____Complications?(list)_____
2. Date_____Doctor_____Hospital_____
   Type of surgery_____
   Helped? Yes_____No____Complications?(list)_____
3. Date_____Doctor_____Hospital_____
   Type of surgery_____
   Helped? Yes_____No____Complications?(list)_____

**SELF CARE:** None_____Other_____
Changed shoes_____ Trimmed callouses_____ Store bought pads or arch supports_____

**ANTICIPATED SURGEY:**

Would consider surgery if the doctor thinks it's necessary?_____
Would not consider surgery?_____

**FACTORS OF PAIN OR DISCOMFORT: check one or more.**

Walking in shoes_____ Being on my feet all day_____
Walking barefooted_____ Cold damp weather_____
First getting up in the morning_____ Walking while carrying loads_____
Walking after resting or sitting_____ Climbing stairs or ladders_____
At rest or at night_____ Squatting_____
Other_____

**FACTORS OF RELIEF: check one or more.**

Staying off my feet_____ Removing shoes_____
Elevating feet_____ Hanging feet over side of bed_____
Applying ice_____ Special shoes(what type?)_____
Rubbing my feet_____ Other_____

**FREQUENCY OF PAIN:** check one or more. None_____
Some pain is always present_____
Frequency of pain depends on activities_____

**FREQUENCY OF SWELLING: check one or more**. None_____
Some swelling is always present_____
Frequency of pain depends on activities_____

**FREQUENCY OF INSTABILITY: check one or more.** None_____
(For patients with ankle problems: Instability means that the ankle feels as though it will give out, actually gives out, or "resprains.")
Walking on uneven surfaces_____ Playing sports_____ Type of sports?_____
Instability occurs several times a week_____ a month_____ a year_____
Instability is becoming more frequent_____ less frequent_____

**AIDS FOR WALKING: (used frequently) check one or more.** None_____
Wheelchair_____ Crutches_____ Cane_____ Other_____

| **REGULAR ACTIVITIES PRIOR TO PAIN OR INJURY** | **CURRENT LIMITATIONS** | |
|---|---|---|
| | **Do with difficulty** | **Unable to do** |
| Bicycling_____ | _____ | _____ |
| Bowling_____ | _____ | _____ |
| Golfing_____ | _____ | _____ |
| Running_____ | _____ | _____ |
| Miles a week_____years of running_____ | | |
| Walking_____ | _____ | _____ |
| Miles a week_____years of running_____ | | |
| Other sports_____ | _____ | _____ |
| House/yard work_____ | _____ | _____ |
| Usual occupation_____ | _____ | _____ |
| Other_____ | _____ | _____ |

**PREVIOUS INJURIES RELATED TO THIS PROBLEM ( same foot or ankle).** None_____
Date of previous injury_____ Describe_____
When present problem began was this previous problem completely resolved?_____

**ORTHOPAEDIC PROBLEMS:** None_____
Back____ Neck_____ Shoulder_____Arm_____ Hand_____Hip_____Knee _____Leg_____
Describe problem_____

**MEDICAL ILLNESSES: Check as many as are applicable.** None_____

| | | | |
|---|---|---|---|
| Diabetes, insulin yes___ no___ | _____ | age at onset | _____ |
| Rheumatoid arthritis(type) | _____ | age at onset | _____ |
| Degenerative arthritis | _____ | Lung disease | _____ |
| Gout | _____ | Stomach/intestinal (type) | _____ |
| Psoriasis | _____ | Liver disease(hepatitis) | _____ |
| Heart disease(type) | _____ | Kidney disease(type) | _____ |
| High blood pressure | _____ | Bladder problems | _____ |
| Bad circulation in feet | _____ | Seizures | _____ |
| Bad leg veins | _____ | Stroke | _____ |
| Bleeding tendency | _____ | Nerve disease(type) | _____ |
| Anemia | _____ | Psychiatric illness(type) | _____ |
| Sickle cell trait | _____ | Glaucoma | _____ |
| Ankle Swelling | _____ | Cancer(type) | _____ |
| Other_____ | _____ | Thyroid disease | _____ |
| Other_____ | _____ | | |

**CURRENT MEDICATIONS:** None_____

| Name of medication | Dose | Times a day | Duration of use(months or years) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ASPIRIN (Anacin, Empirin etc.):** I take more that 10 tablets a month Yes____No____
**PAST MEDICATIONS:** I have taken cortisone pills in the past Yes____No____

**ALLEGIES:** None_____
**(include medicine, adhesive tape, iodine products, xray dyes, etc.)**

| **Medication, etc.** | **Reaction: A = anaphylaxis (unable to breathe) R = rash, N = nausea, O = other** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**OPERATIONS: (other than foot and ankle)** None_____ 

1. Date_____Type_____
   Complications?_____
2. Date_____Type_____
   Complications?_____
3. Date_____Type_____
   Complications?_____
4. Date_____Type_____
   Complications?_____

**HOSPILIZATIONS: (other than for surgery or childbirth)** None_____

1. Date_____Diagnosis_____

2. Date_____Diagnosis_____

3. Date_____Diagnosis_____

4. Date_____Diagnosis_____

**LUNGS AND LIVER:**

_____I have never smoked. _____I am a smoker. (_____picks per day).
_____I have been a smoker and I stopped smoking in _____.
_____I drink more that 3 alcoholic beverages per day, several times a week.
_____I do not use alcohol.

**FAMILY HISTORY: Do/did any "blood relatives" have any of the following?**

| Disease | Family relationship |
|---|---|
| Cancer_____ | _____ |
| Heart disease_____ | _____ |
| Diabetes_____ | _____ |
| Arthritis_____ | _____ |
| Bone disease_____ | _____ |
| Sickle cell trait/anemia_____ | _____ |
| Foot and ankle problem_____ | _____ |

**SOCIAL HISTORY:**

Present occupation: _____Duration:_____
Home members
_____Live alone
_____Live with family members (relationship)_____
_____Other_____

**HEIGHT_____ WEIGHT_____ SHOE SIZE____ WIDTH_____**

_____ _____
Print Name of patient Date

_____ _____
Signature of patient Date

_____ _____
Print Name of person completing form, if other than patient Date

_____ _____
Signature of person completing form, if other than patient Date