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?_____