1206D-2212

Name: _____ Date of Birth: _____ ☐ M ☐ F

Chief Complaint: ☐ Right ☐ Left ☐ Both ☐ Foot ☐ Ankle

History of Problem: _____

Duration (Length of Time): _____

Intensity of Pain (Scale 0-10; 0=No Pain, 10=Worst Pain Imaginable): _____

Past treatment for this problem: _____

Previous Surgeries on this area: ☐ No ☐ Yes

Type: _____ Date: _____

Type: _____ Date: _____

Medical History (Check all medical problems you have been or currently are being treated for):

| N | Y | | N | Y | | N | Y | |
|---|---|---|---|---|---|---|---|---|
| | | High Blood Pressure | | | Stroke | | | Parkinson's Disease |
| | | Heart Disease/Heart Attack | | | Blood Clots | | | Multiple Sclerosis |
| | | Irregular Heart Rhythm | | | Diabetes | | | Seizure/Epilepsy |
| | | Peripheral Vascular Disease | | | Cancer | | | Nerve Injury |
| | | Emphysema/COPD/Asthma | | | Ulcer | | | Hepatitis ☐ A ☐ B ☐ C |
| | | Sleep Apnea | | | Kidney Disease | | | Immunodeficiency Disease (HIV) |
| | | Tuberculosis (TB) | | | Thyroid Disease | | | Degenerative Spine Disease Sciatica |
| | | GERD Heartburn | | | Brain Injury | | | Arthritis/Osteoporosis |

Surgical History (List all other surgeries you have had):

| Year | Type of Surgery | Year | Type of Surgery |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

List all Medications you take regularly (include non-prescription meds): ☐ See Attached List

| Name & Dose | How Often | Name & Dose | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**ORTHOPAEDIC SURGERY**
**FOOT AND ANKLE CENTER**
**NEW PATIENT QUESTIONNAIRE**



PATIENT ID



**WHITE** - MEDICAL RECORD

Allergies: ☐ No ☐ Yes If yes, please list medication and reaction to it below:

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |

Complications (Check and explain any complications you have had after any of your surgeries):

| | | | |
|---|---|---|---|
| | Infection: | | Pneumonia: |
| | Bleeding: | | Lung Problems: |
| | Blood Clot: | | Severe Nausea/Vomiting: |
| | Anesthesia Reaction: | | Other: |

Social History:

Occupation: _____ ☐ Full Time ☐ Part ☐ Retired

Do you drink alcohol? ☐ No ☐ Yes If yes, how much? ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20 or more drinks/week

Do you currently smoke? ☐ No ☐ Yes If yes, number of packs per day: _____ For _____ years

Did you ever smoke? ☐ No ☐ Yes If yes, number of packs per day: _____ For _____ years Year quit: _____

History of Substance Abuse? ☐ No ☐ Yes If yes, what substance: _____

Review of Symptoms (Check any recent/current problems, check symptoms or write in other):

| N | Y | System | Symptoms/Problems | Other |
|---|---|---|---|---|
| | | General | ☐ Fever, ☐ Unexplained Weight Loss/Gain, ☐ Weakness | |
| | | Eyes/Vision | ☐ Glasses, ☐ Blurred, ☐ Double, ☐ Dry Eyes | |
| | | Ears, Nose, Throat, Mouth | ☐ Vertigo, ☐ Sinusitis, ☐ Hoarseness, ☐ Loss of Hearing | |
| | | Heart | ☐ Chest Pain, ☐ Murmurs, ☐ Palpitations, ☐ Irregular Rhythm | |
| | | Lung | ☐ Short of Breath, ☐ Asthma, ☐ Cough, ☐ Wheezing | |
| | | Circulation | ☐ Blood Clots, ☐ Swelling, ☐ Claudication, ☐ Varicosities | |
| | | Digestive Tract | ☐ Diarrhea, ☐ Constipation, ☐ Ulcers, ☐ GERD, ☐ Pain | |
| | | Kidney/Urinary | ☐ Stones, ☐ Burning, ☐ Itching, ☐ Bleeding | |
| | | Skin/Breast | ☐ Rash, Lump, ☐ Itching, ☐ Hair or Nails Change | |
| | | Endocrine | ☐ Excess Thirst, ☐ Decreased Energy, ☐ Diabetes | |
| | | Neurologic | ☐ Balance, ☐ Numbness/Tingling, ☐ Seizure, ☐ Tremor | |
| | | Psychiatric | ☐ Depressions, ☐ Anxiety, ☐ Sleep Disorder | |
| | | Blood/Lymph | ☐ Bleeding Problems, ☐ Easy Bruising, ☐ Transfusion | |
| | | Musculoskeletal | ☐ Fracture, ☐ Arthritis, ☐ Motion Loss, ☐ Cramps/Spasms | |

Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

| | | |
|---|---|---|
| High Blood Pressure: | Asthma: | Cancer: |
| Heart Attack: | Lung Disease: | Stroke: |
| Coronary Artery Disease: | Tuberculosis: | Diabetes: |
| Heart Valve Disease: | Thyroid Disease: | Kidney Disease: |
| Irregular Heart Rhythm: | Blood Clots: | Arthritis: |
| Peripheral Vascular Disease: | Seizures: | Osteoporosis: |
| Hepatitis: ☐ A ☐ B ☐ C | Immunodeficiency: | Other: |

I certify that the foregoing statements are true to the best of my knowledge.

Patient Signature: _____ Date: _____ Time: _____

Physician (Print): _____ (Signature): _____ Date: _____ Time: _____

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Vital Signs:

Temp: _____ BP: _____ HR: _____ RR:_____ Pain: _____ Height: _____ Weight: _____ BMI: _____

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____