Foot & Ankle Orthopaedic Patient Questionnaire

Date:_____________________
Name:____ Male Female
Date of Birth: ____________Age: ______Height: __________ Weight: ______lbs.
Mailing Address: ____

Referring
Physician:_____________________________Address:___________________________

Primary
Care:__________________________________Address:__________________________

What is your chief complaint for seeing the doctor today?

____

How long has this problem (pain) been present?

____

Has the problem (pain) worsened recently? O No O Yes
If yes, how recently?_____________

What would you say started the pain—exercise, fall, accident, etc…?

____

Location of the pain: _________________________________

How would you describe the pain? O Sharp O Burning O Dull O Aching
Please rate the severity of your pain: O Mild O Moderate O Severe
Does anything help with easing this pain? O No O Yes If yes, please give example:____

Please check any treatments that you have tried below and the result of this treatment for your pain:

O Physical Therapy/Exercise ______________________________________
O Massage/Ultrasound ____
O Steroid Injections ____
O Cast ____
O Walker Boot ____
O Off the shelf brace ____
O Custom made brace ____
O Off the shelf shoe insert ____
O Custom molded shoe insert ____
O Other ____

Please List any other physicians you have seen for this problem:			
Physician	**Specialty**	**City**	**Treatments**

Are you currently taking any medications for this problem? O Yes O No

Medication	Dose	Outcome

Please list all medications which you are currently taking:

Medication	Dose	Reason

Do you have any medication allergies? O No O Yes If yes, please list below:

Medication	Reaction
	O Rash O Swelling O Wheezing O Shock O Stomach upset O Other
	O Rash O Swelling O Wheezing O Shock O Stomach upset O Other
	O Rash O Swelling O Wheezing O Shock O Stomach upset O Other

Surgical History

Have you ever had general anesthesia? O Yes O No

If yes, did you have any problems related to the anesthesia? O Yes O No

Please describe any problems:____

Please list any surgical procedures you have had performed:

Operation	Date	Surgeon/Hospital

Family History

Family Member	Alive	Deceased	Age	Health status or cause of death
Mother's mother				
Father's mother				
Mother's father				
Father's father				
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				

Social History (Check all that apply)
Marital Status: O Married O Single O Co-Habituating O Divorced O Widowed
Work Status: O Employed O Unemployed O Retired O Disabled O Other
Current or past occupation: ________________________________How Long?_________
Do you have children? O Yes O No How Many: _______ Boys _______ Girls

Please choose your current living situation: O Alone O Spouse O Significant Other
O Children O Roommate O Other _______________

Please choose which of the following describes your tobacco use: O Never O Cigarettes
O Cigar O Pipe O Chew/Smokeless Tobacco
___________ Packs per day for ________ Years (Total) Quit ________ Years Ago

Please choose which of the following best describes your alcohol use: O Never O Rare
O Social O Frequently (more than twice per week) O Alcoholic O Recovering Alcoholic

Please indicate any recreational drug use: O None O In Past O Currently
Types of drugs:____

As a result of your problem, have you filed either of the following?
O Lawsuit O Workers' Compensation Claim

Review Of Systems

Do you suffer from problems with any of the following:

Constitutional:

Fever O Yes O No

Chills O Yes O No

Appetite Loss/Weight Loss O Yes O No

Ear, Nose and Throat:

Hearing Loss O Yes O No

Hoarsness O Yes O No

Respiratory

Emphysema O Yes O No

Asthma O Yes O No

Lung Disease O Yes O No

Pneumonia O Yes O No

Tuberculosis O Yes O No

GU

Kidney Failure O Yes O No

Kidney Stones O Yes O No

Musculoskeletal

Fractures O Yes O No

Osteoarthritis O Yes O No

Rheumatoid Arthritis O Yes O No

Osteoporosis O Yes O No

Gout O Yes O No

Endocrine

Diabetes O Yes O No

Controlled with insulin O Yes O No O N/A

Controlled with oral meds O Yes O No O N/A

Please check any glandular problem which apply

O Thyroid O Adrenal O Pituitary

Eyes:

Blurred Vision O Yes O No

Vision Loss O Yes O No

Do you wear corrective lenses? O Yes O No

Cardiovascular

Heart Attack O Yes O No

Heart Failure O Yes O No

Stroke O Yes O No

High Blood Pressure O Yes O No

Poor Circulation O Yes O No

GI

Stomach Ulcers O Yes O No

Hiatal Hernia O Yes O No

Gastric Reflux O Yes O No

Hepatitis O Yes O No

Cirrhosis O Yes O No

Skin/Integumentary

Rash O Yes O No

Hives O Yes O No

Eczema O Yes O No

Neurological

Neuropathy (loss of feeling) O Yes O No

If yes, where ___________________________

Seizure O Yes O No

Psychiatric

Depression O Yes O No

Poor Sleep O Yes O No

Anxiety O Yes O No

Hematology/Lymphatic

Blood clot in leg O Yes O No

Blood clot in lung O Yes O No

Bleeding Disorder O Yes O No

Anemia O Yes O No

HIV/AIDS O Yes O No

Foot and Ankle Ability Measure (FAAM) Activities of Daily Living Subscale

Please answer **every question** with **one response** that most clearly describes your condition within the past week. If the activity in question is limited by something other than your foot or ankle, please mark this as **not applicable (N/A)**

Activity:	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Standing						
Walking on even ground						
Walking on even ground without shoes						
Walking up hills						
Walking down hills						
Going up stairs						
Going down stairs						
Walking on uneven ground						
Stepping up and down curbs						
Squatting						
Coming up on your toes						
Walking initially--first steps						
Walking 5 minutes or less						
Walking approximately 10 minutes						
Walking 15 minutes or greater						

Because of your **foot and ankle** how much difficulty do you have with:

Activity:	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Home Responsibilities						
Activities of Daily Living						
Personal Care						
Light to Moderate Work (standing/walking)						
Heavy Work (push/pulling, climbing, carrying)						
Recreational Activity						

How would you rate current level of function during your usual activities of daily living on a scale of 0 to 100; with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual daily activities?

__________%

Foot and Ankle Ability Measure (FAAM) Sports Subscale

Because of your **foot and ankle**, how much difficulty do you have with each of the following:

Activity:	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Running						
Jumping						
Landing						
Starting and Stopping Quickly						
Cutting/Lateral Movements						
Low Impact Activities						
Ability to perform activity with your normal technique						
Ability to participate in your desired sport for as long as you would like						

How would your rate your current level of function during your **sports related** activities from 0 to 100; with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual activities. ______________ %

Patient Signature: ________________________ **Date:** __________

FOR OFFICE USE ONLY
I have read and confirmed the above information with the patient.
Physician: ____________________________________ MD Date_____________
Physician: ____________________________________ MD Date_____________
Physician: ____________________________________ MD Date_____________
Physician: ____________________________________ MD Date _____________