OrthoTexas
Orthopedics & Sports Medicine

ANKLE / FOOT

Was this an injury or did it occur over time?_____

How long have you had this problem or what was the date of your injury?_____

Which foot has the problem? Left / Right

Where do you have the problem? Ankle / Foot / Heel / Toes: 1 (big) / 2 / 3 / 4 / 5 (pinky)

If an injury, describe how it occurred:_____

Have you had this or a similar problem before? Yes / No
If yes, how was it treated?_____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull
Constant Burn	Come and go	Pins & needles	Electric
Explosive	Unrelenting	Throbbing	Other:_____
Constant	Intermittent	Chronic	_____
Getting better	Getting worse	Unchanged	
Worse in the morning	Worse in the evening	Worse at night	

What makes your pain **worse**?_____

What makes your pain **better**?_____

Medications used for this problem:_____

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other_____

Do you have numbness or tingling? Yes / No If yes, where?_____

Do you have swelling? Yes / No If yes, where?_____

Have you had any surgery on this area? Yes / No
Please list:_____

Do you have any other problems not previously described? Yes / No
Please describe:_____

Referring Physician:_____

Other Physician(s) you have seen for this problem:_____

Date(s) of work/school missed for this problem:_____

Is there an attorney involved with this problem? Yes / No
If yes, please provide additional information:_____

_____

Patient Name *(please print)*:_____

Patient Signature:_____ Date:_____

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