



HISTORY OF FOOT & ANKLE

PX 01-21

Orange Park 981 Kingsley Ave (904) 269-9595

Jacksonville Beach 2710 3rd St South (904) 269-9595

Patient Name _____

Primary Care Physician _____ Date of Last Visit _____

Chief complaint:

- Left foot
- Left ankle
- Right foot
- Right ankle

When did the pain start?

- 1 week
- 1 month
- 1 year
- Other _____

Nature of pain? Mark all that apply.

- Dull
- Tenderness
- Constant
- Other _____
- Numbness
- Throbbing
- Intermittent
- Tingling
- Acute
- Aching
- Sharp
- Chronic
- Stabbing

History of pain? Mark all that apply.

- Morning
- While resting
- Afternoon
- After sleeping
- Evening
- After periods of inactivity
- Night
- Wakes you from sleep
- Sitting
- Other _____

Symptoms? Mark all that apply.

- Swelling
- Bumps
- Discolored nails
- Redness
- Tiredness
- Other _____
- Bruising
- Cramping
- Burning
- Numbness
- Itching
- Skin flaking

Severity of pain?

- ☺ 1 2 3 4 5 6 7 8 9 10 ☹

Specifically describe your most important problem:

Self treatment:

- Rest
- Medication
- Change shoes
- Ice
- Change activities
- Other _____

Professional treatment:

Have you seen anyone for this problem? Yes No

If yes, who _____

What advice or treatment was given?

Fall risk:

- Do you ever shuffle your feet? Yes No
- Are you unsteady on your feet? Yes No
- Do you ever stumble? Yes No
- Have you fallen from foot/ankle problems? Yes No
- Have you suffered an injury from any fall? Yes No

Have you discussed fall risks with your primary physician?

- Yes
- No

Would you like to discuss this further with Dr. Tellam?

- Yes
- No

What shoes do you avoid and why?

- Tennis shoes
- Heels
- Boots
- Work shoes

How has this affected your work or recreational activities?

What changes have you made in your home, environment or footwear to reduce your risks?

PATIENT SIGNATURE:

DATE: