ANKLE & FOOT ASSOCIATES
HISTORY OF FOOT OR ANKLE PROBLEMS

Patient Name: _____ Date:_____

Primary Care Physician:_____appx date of last visit_____

1. Chief complaint: (**circle**) foot pain, ankle pain, heel pain, nail fungus, ingrown nail, warts, diabetic foot exam, other_____

2. Onset: (**circle)** When did the pain start? eg: 1 week, 1 month, 1 year, other_____

3. Nature of Pain: (**circle all that apply)**
Type of pain: dull, numbness, tingling, sharp, tenderness, throbbing, acute, chronic, constant, intermittent, aching, stabbing

4. History of pain: (**circle all that apply**)
Morning, afternoon, evening, night, after periods of inactivity, while resting, sitting, after sleeping, wakes you from sleep other_____

5. Symptoms: (**circle all that apply**) Severity of Pain: **Please Circle** 1 2 3 4 5 6 7 8 9 10
Do you have? : swelling, redness, bruising, burning, itching, numbness, discolored nails, skin flaking, bumps, tiredness, cramping, other_____

6. Past Treatment:

A.Self: What have you done to alleviate pain? (rest, ice, medication, change activities, change shoes) other_____

B. Professional: Have you seen anyone for this problem? Yes, No What advice or treatment was given?_____

7. Footwear: (**circle**)
What shoes can you wear? eg: tennis shoes, heels, boots, work shoes
What shoes do you avoid and why? eg: tennis shoes, boots, heels, work shoes

8. Work/Recreation:
How has this affected your work or recreational activities?

9. Fall Risk:
Do you ever shuffle your feet? **Y N** Do you ever stumble? **Y N**
Are you unsteady on your feet? **Y N** Have you fallen from foot/ankle problems? **Y N**
Have you suffered an injury from any fall? **Y N**

Have you discussed this with your primary physician? _____yes _____no

What changes have you made in your home, environment or footwear to reduce your risks? Would you like to discuss this further with Dr. Tellam?

_____
Patient signature/date