ROSEVILLE ORTHOPEDIC
Surgery & Sports Medicine

Foot & Ankle Surgery Questionnaire

Patient name:_____

Date: _____

Age:_____ Date of Birth:_____

Primary Care Physician: _____

Referring Physician:_____

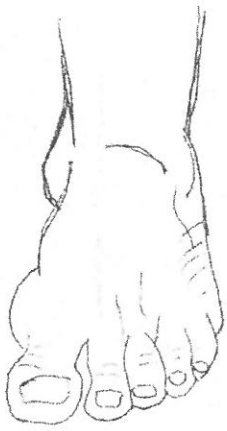
Office Use Only

Ht _____ Wt _____ BP _____

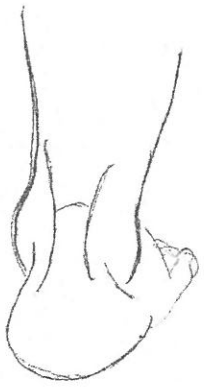
WHERE IS YOUR PAIN NOW?

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

Front



Back



Ache
^^^^^
^^^^^
^^^^^

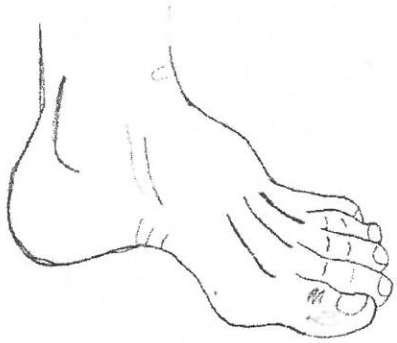
Numbness
OOOO
OOOO
OOOO

Pins & Needles
= = = =
= = = =
= = = =

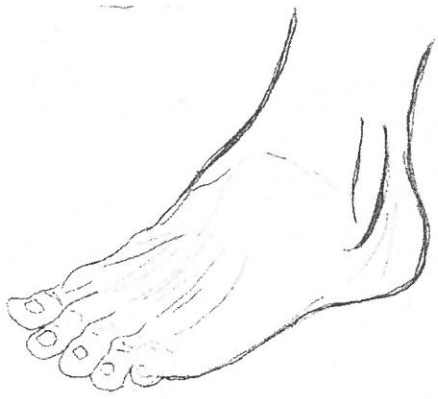
Burning
XXXX
XXXX
XXXX

Stabbing
/////
/////
/////

Medial

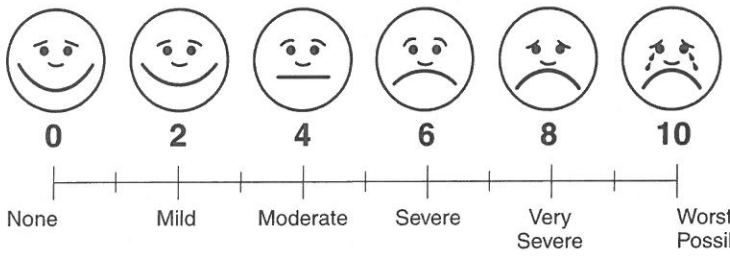


Lateral



Grade your overall Pain

Please place an X on the hash mark that most accurately describes your overall degree of pain now.



Name: _____

CURRENT HISTORY

What is the main reason for your visit today?

_____

How long has this been a problem?

_____ Date of onset (if known) _____ Days _____ Weeks _____ Months _____ Year

☐ Further Comments: _____

Have you been treated by any other healthcare provider for this condition? ☐ Yes ☐ No

If yes, please list: _____

Is there a lawsuit associated with this injury: ☐ Yes ☐ No If yes, attorney name: _____

Is this a workman's compensation claim: ☐ Yes ☐ No If yes, date of injury: _____

Current problem began: (Check all that apply)

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting ☐ Fall

☐ Bending ☐ Pulling ☐ Other: _____

BRIEFLY describe how the problem started: _____

_____

What bothers you most about your foot and/or ankle? (check all that apply)

☐ Pain ☐ Swelling ☐ Numbness/Tingling ☐ Feels unstable ☐ Deformity

Current problem is: ☐ Getting worse ☐ Improving ☐ Stays the same ☐ Comes / Goes

Prior to the onset of your current problem:

- **Any recent Injury?** ☐ Yes ☐ No If so, date/details: _____
- **Any recent increase in activities?** ☐ Yes ☐ No If so, please describe: _____
- **Any recent changes in shoe gear?** ☐ Yes ☐ No If so, please describe: _____

What type of shoes do you typically wear? _____

What distance can you walk before your symptoms begin?

☐ Unlimited ☐ 4 - 6 blocks ☐ 1 - 3 blocks ☐ less than 1 block ☐ Other _____

What have you tried for your symptoms thus far and have they helped?: *(check all that apply, circle Yes if helped)*

☐ Physical Therapy (Y / N) ☐ Acupuncture (Y / N) ☐ Altered shoe gear (Y / N) ☐ Altered Activity

☐ Surgery (Y / N) ☐ Brace (Y / N) ☐ Cortisone injection (Y / N) _____

☐ Exercise (Y / N) ☐ Custom shoe inserts (Y / N) ☐ Soaks (Y / N) ☐ Medications

☐ OTC Shoe Inserts (Y / N) ☐ Padding (Y / N) _____

Indicate which activities WORSEN your symptoms:

☐ Getting up from a seated position ☐ Standing ☐ Walking ☐ Running ☐ Shoe type_____

☐ Uneven ground ☐ Driving ☐ Household Chores ☐ Exercise_____ ☐ Other _____

Is your pain worse:

☐ In the morning ☐ Mid-day ☐ In the evening ☐ Constant: _____

Is your pain better:

☐ In the morning ☐ Mid-day ☐ In the evening ☐ Never: _____

- **Are there any other general foot or ankle health information we should know about?** ☐ Yes ☐ No

If so, please describe: _____

Which studies of your foot or ankle, if any, have you had in the last 2 years:

☐ Regular X-rays ☐ CT Scan ☐ MRI ☐ Vascular non-invasive test ☐ EMG

Have you ever had foot or ankle surgery before: ☐ Yes ☐ No

Please list ALL prior surgeries with dates (Month/Year):

_____

_____

_____

_____

Name: _____

MEDICAL HISTORY

Do you have a history of:

Blood clots	YES ☐	NO ☐	Gout	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Arthritis	YES ☐	NO ☐
Adverse Reaction to Anesthesia	YES ☐	NO ☐	Hypertension	YES ☐	NO ☐
Cardiac Disorders	YES ☐	NO ☐	Cancer	YES ☐	NO ☐
			Mental Health Disorders	YES ☐	NO ☐

Other diagnosis: _____

MEDICATION ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No

Are you allergic to any local anesthetic? ☐ Yes ☐ No

Are you allergic to any metal? ☐ Yes ☐ No

If yes, list the medications and your reaction.

Medication	Reaction
1.	
2.	
3.	
4.	

MEDICATION AND DOSAGE

If you brought a list, please attach.

Medication	Strength	# of pills per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

How often do you exercise? _____

Please list exercise activities: _____

Are you currently: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

If employed, what is your occupation: _____

Does your occupation require heavy labor: ☐ Yes ☐ No

If so, please describe: _____

Are you on Disability: ☐ Yes ☐ No If yes, Date started: _____

Are you: ☐ Married/Partnered ☐ Single ☐ Divorced/Separated ☐ Widowed

Number of Children, if any: _____

Do you smoke or use Tobacco products: ☐ Yes ☐ No

If yes, for how long: _____

Packs smoked per day: ☐ <½ ☐ ½ ☐ 1 ☐ 2 ☐ 3 ☐ 4

Have you quit smoking? ☐ Yes ☐ No If yes when? _____

Do you drink Alcohol: ☐ Yes ☐ No

If yes, how often: ☐ 1-2 ☐ 3-5 ☐ >5 per ☐ day ☐ week ☐ month

Do you use any recreational drugs: ☐ Yes ☐ No If yes, which drugs: _____

Name: _____

FAMILY HISTORY

List any blood relatives with a history of:

- ☐ Blood clots / excessive bleeding — Relationship _____
- ☐ Adverse reaction to anesthesia — Relationship _____
- ☐ Cardiac disorders — Relationship _____
- ☐ Cancer — Relationship _____
- ☐ Diabetes — Relationship _____
- ☐ Auto immune disorders — Relationship _____

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

			Please describe all yes answers
Skin	YES ☐	NO ☐	_____
Ears, Nose, Throat	YES ☐	NO ☐	_____
Cardiac/High blood pressure	YES ☐	NO ☐	_____
Lungs, (Asthma, Infection)	YES ☐	NO ☐	_____
Stomach/Digestion	YES ☐	NO ☐	_____
Bladder/Bowel problems	YES ☐	NO ☐	_____
Hematologic/Bleeding problems	YES ☐	NO ☐	_____
Diabetes	YES ☐	NO ☐	_____
Cancer	YES ☐	NO ☐	_____
Musculoskeletal	YES ☐	NO ☐	_____
Neurological	YES ☐	NO ☐	_____
Psychiatric problems	YES ☐	NO ☐	_____
Reproductive/Sexual Problems	YES ☐	NO ☐	_____
Fever/Chills	YES ☐	NO ☐	_____
Night Sweat	YES ☐	NO ☐	_____
Night Pain	YES ☐	NO ☐	_____
Unexpected Weight Loss	YES ☐	NO ☐	_____

Patient Signature: _____ **Date:** _____

*** Please hand-carry your prior films (Xray, MRI, CT, etc) with you to your appointment.**