Patient Name: _____
Date of Birth: _____

Foot & Ankle New Patient Evaluation Form:

History:

What are you seeing us for today?_____

Where is the pain located? _____

How long have you had this?_____

What led to the pain (i.e. work injury, sports injury, motor vehicle, etc?_____

_____

How would you describe the pain or symptoms (swelling, burning, sharp, shooting, etc)? _____

_____

What is your pain level on most days? ___/10 What is your pain level today? ___/10

Please check the following that you have tried: ___Activity Modification; ___Shoe wear Adjustments; ____PT or Home Exercises; ____Orthotics/Inserts; ____Soft Braces; ___Hard Braces; ___Injections; Other:
_____

Have you had surgery on either foot or ankle before (if yes, please explain): ___No; ___Yes, Surgery performed:_____

Medical and Social History (please check those that apply)

Do you have a history of diabetes? ___Yes

If yes, what is your current A1c number? _____

Do you have a history of neuropathy (numbness, tingling, burning) in your legs or feet? ___Yes

Do you have a history of blood clots? ___Yes

Are you on a blood thinning medication? ___Yes

Do you smoke or use nicotine products (cigarettes, cigars, smokeless chewing tobacco, vaping)? ___Yes; If yes how much: _____

What is your occupation? _____

How active are you outside of work?_____