FOOT ANKLE
SPECIALISTS OF AMES

Patient Name: _____ Date of Birth: _____ Age: _____ Todays Date: _____

What is brings you in today?_____

Xray's, CT's or MRI's taken? Yes No If yes: When: _____ Where: _____

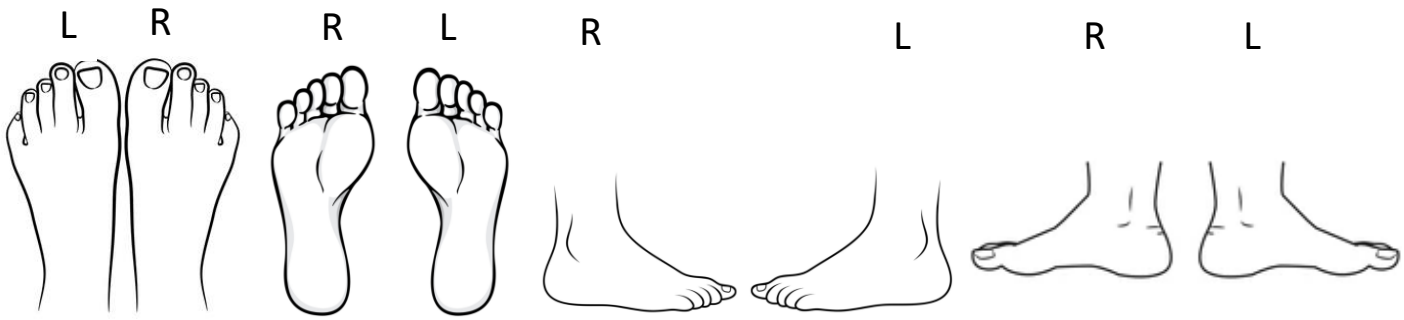
How long has this been bothering you? _____

Have you been seen for this issue before? (circle one) Yes No

If Yes, who did you see? _____ When? _____

Please list any previous Foot/Ankle surgeries: _____

Mark location of the problem(s) with an **X**:



Select all that apply that best describes your pain:

Burning ☐ Sharp ☐ Aching ☐ Weakness ☐ Numbness ☐ Tingling ☐ Stabbing ☐

Shooting ☐ Other (describe): -_____

Is the pain constant? Yes No

If 10 is the worst pain or discomfort you ever had and 0 is no pain or discomfort, how would your rate your pain or discomfort today? (Circle Number) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

What makes your symptoms better? _____

What makes your symptoms worse? _____

Occupation: _____

Shoe Size: _____ Do you wear Orthotics: Yes No If Yes are they custom made for your foot? Yes No

Do you exercise? Yes No If Yes, what type of activities? _____

How many days per week? _____

Have you had a Bone Density Scan (DEXA)? Yes No If yes results were: (circle one): Normal Abnormal

Please complete 2nd page ➡

Patient Name: _____ Date of Birth: _____

Name of PCP: _____ Phone: _____

Preferred Pharmacy : _____ Location:_____ Phone_____

Please list ALL current medications below:

Medication:	Dose / How often	Allergies	Reaction
1._____	_____	1._____	_____
2._____	_____	2._____	_____
3._____	_____	3._____	_____
4._____	_____	4._____	_____
5._____	_____	5._____	_____

Immunizations: Did you receive an influenza vaccine this year? Yes No Last Tetanus/Pertussis date: _____

Have you fallen in the last year? Yes No If yes how many times? _____ Injuries? _____

Do you drink Alcoholic beverages? Yes No If yes, how many drinks? _____ Day / Week / Month

Do you smoke tobacco? Yes No If yes how much? ____ per day

Do you use chewing tobacco? Yes No If yes how much?____ per day

Do you use illegal drugs? Yes No If yes what type? _____

Do you Vape? Yes No If yes how much?____ per day

Do you use CBD products? Yes No If so what kind? _____ How Often? _____

Past Medical/Family History: (check all that apply)

	You	Mother	Father		You	Mother	Father
Anesthesia Complications				Foot/Leg Ulcer			
Anxiety				High Blood Pressure			
Arthritis				High Cholesterol			
Back Pain				Joint Pain			
Blood Clots				Kidney Disease			
Cancer				Osteoporosis			
Depression				Reflux			
Diabetes				Stroke			

Surgical History: (list Left or right and year, along with surgery): _____

_____

Do you currently have any of the following symptoms: (check all that apply)

Fever		Chills		Fatigue		Chest Pain	
Swelling		Wheezing		Coughing		Irregular Heart Beat	
Vomiting		Abdominal Pain		Diarrhea		Pain/bleeding with Urination	
Rashes		Muscle Pain		Joint Pain		Shortness of Breath	
Stiffness		Recent Weight Changes					

Patient Signature

Date