FOOT ANKLE
SPECIALISTS OF AMES

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

What brings you in today?_____

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

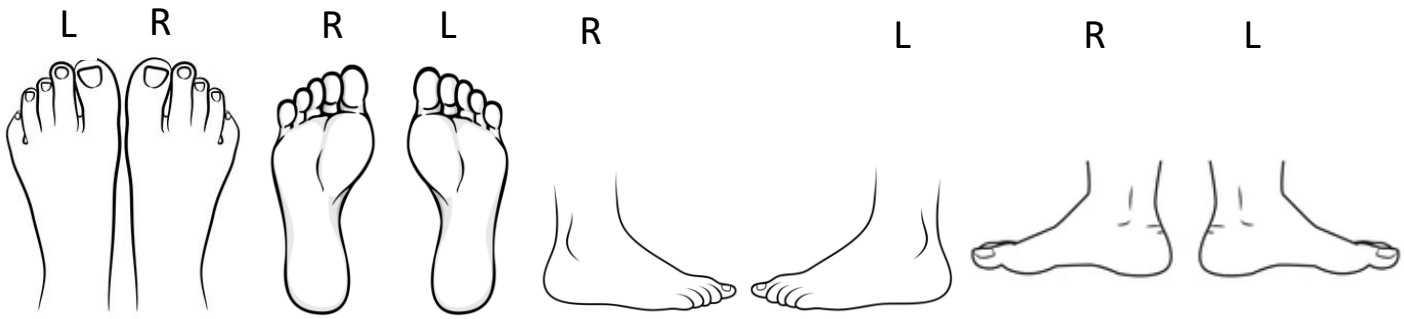
How long has this been bothering you? _____

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

Name of Primary Care provider: _____ Phone: _____

Preferred Pharmacy : _____ Location:_____ Phone_____

Please list ALL current medications below (use additional paper if necessary):

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

Immunization date(s): COVID: _____ influenza:_____ Tetanus/Pertussis: _____

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 If No, Former smoker? Yes No

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				High Blood Pressure			
Anxiety				High Cholesterol			
Arthritis				Joint Pain			
Back Pain				Kidney Disease			
Blood Clots				Osteoporosis			
Cancer				Reflux			
Depression				Restless Leg			
Diabetes				Sleep Apnea			
Foot/Leg Ulcer				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					

Signature:_____ Date: _____