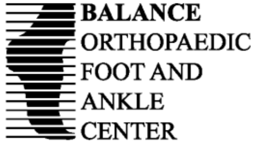


PATIENT INFORMATION RECORD

RONALD W. SMITH, M.D.
2840 Long Beach Blvd. #440 Long Beach, California 90806
Phone 562-424-9444 ● Fax 562-490-0434
rsmith@memnet.org ● www.BalanceOrthoFoot.com

Today's Date ____________

Chart Number ____________

PATIENT — E-mail:

Patient Legal Name (Last, First, Middle)	Date of Birth	Sex	Social Security No	Home Phone

Stree Address	City, State	Zip Code	**Cell Phone**

Can confidential messages be left on your answering machine or voicemail? ☐ Yes ☐ No	Drivers License Number	Marital Status	Your Work Phone

Patients Employer	Employer Address, City, State, Zip	Employers Phone

Spouse's Name (Last, First, Middle) ☐ Not Applicable	Spouse's Date of Birth	Sex	Spouse's Social Security No	Spouse's Cell Phone

Spouse's Employer	Spouse's Employer Address, City, State, Zip	Spouse's Work Phone

Have we ever treated any members of your family?

IF THE PATIENT IS A MINOR — **Not Applicable** ☐

Mother's Name	Address, City, State, Zip	Mother's Home Phone

Mother's Employer	Busniess Phone Number	Mother's Social Security

Mother's Employer's Address, City, State, Zip

Father's Name	Address, City, State, Zip	Father's Home Phone

Father's Employer	Busniess Phone Number	Father's Social Security

Father's Employer's Address, City, State, Zip

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Medicare ☐ NA ☐ Medicaid ☐ NA ☐ — Medicare or Medicaid Number	Medicare ☐ NA ☐ Medicaid ☐ NA ☐ — Medicare or Medicaid Number
InsuranceName	InsuranceName
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone
ID Number	ID Number
Group Number	Group Number
Insured Name	Insured Name
Insured Date of Birth	Insured Date of Birth

INJURY ☐ Date: — **Not Applicable** ☐

Location at time of injury:

Home ☐ Work ☐ Auto ☐ Other (describe) ☐

PROVIDER'S FINANCIAL POLICY

Please note that payment in full is required at the time of service. For your convenience, we accept personal checks, Visa, Master Charge or American Express, as well as cash. Any insurance coverage that you may have is intended to protect you against financial loss and not as payment in full for your care.. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by (the patient) (or provider?) in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the listed medical insurance, either electronically or manually, by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to be paid to the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S TREATMENT AUTHORIZATION

I authorize treatment by **Balance Orthopaedic Foot and Ankle Care.** I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all the charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

_______________________ _______________________ ____________

Patient's Name (Please Print) Signature of Patient/Guardian Date

TREATMENT OF MINOR

I authorize Balance Orthopaedic Foot and Ankle Care to treat a minor named below.

_______________________ _______________________

Minor's Name Signature of Parent / Guardian

____

Date

ORTHOPAEDIC SURGERY
PRACTICE LIMITED
TO THE
FOOT AND ANKLE
CHILDREN & ADULTS

A Medical Group, Inc

RONALD SMITH, M.D.

Dear Patient,

We are pleased that you have selected our office for your orthopaedic foot and ankle care.

<u>Please fill out the enclosed forms completely, marking the "NONE" boxes where appropriate and listing where indicated the approximate dates of previous foot and ankle services, treatments, and evaluations.</u>

The forms are detailed but allow us to have information that helps to provide comprehensive medical or surgical care for your foot and ankle.

Please bring with you all X-RAYS, CT AND BONE SCAN STUDIES, AND MRI FILMS AND REPORTS that you have had done in regard to your foot or ankle problem.

Thank you for your assistance. We look forward to meeting you.

Sincerely,

Ronald W. Smith, M.D.

2651 ELM AVE., SUITE 205, LONG BEACH, CA 90806 • 562/424-9444 • FAX 562/988-0309 • E-MAIL rsmith@memnet.org

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

Last ________________ First ________________ M.I. ___ Age ___ Todays Date _______________

I have brought in x-rays or other images today: Yes ☐ No ☐
Source of x-rays/images (office or hospital name) ____

Occupation ____ Duration _______________

REFERRING PARTY: (Please give name)
Physician ___________________________________ Phone __________________ Fax __________________
Address ____________________________________ E-Mail __________________
City _______________________________________ State ___________________ ZIP __________________
Friend _____________________________________ Family Member ___________
Insurance Company ____ Attorney ______________
Other ____

PERSONAL PHYSICIAN (Same as referring physician ☐)
Name _______________________________________ Phone __________________ Fax __________________
Address ____________________________________ E-Mail __________________
City _______________________________________ State ___________________ ZIP __________________
Date of last visit _____________________

PRESENT GOAL IN SEEKING EVALUATION: Check one or more.
Relief of pain ☐ Correction of deformity ☐ Improvement of appearance ☐
Second opinion ☐ Other ____

MAIN PROBLEM: Check one or more.
Pain or aching ☐ Swelling ☐ Weakness ☐ Stiffness ☐ Deformity ☐ Lump ☐
Instability or giving out ☐ Other ____

LOCATION & DURATION OF MAIN PROBLEM: Check one or more. (indicate # of weeks, months, years)

Problem:			Duration Of Symptoms			Or Date Of Onset
Leg	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Ankle	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Heel	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Bunion	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Top of arch	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Sole of arch	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Side of the foot	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Ball of foot	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
Great toe	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
2nd toe	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
3rd toe	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
4th toe	R ☐	L ☐	# __ weeks	# __months	# __ years	___________
5th toe	R ☐	L ☐	# __ weeks	# __months	# __ years	___________

* If multiple problems, indicate the most severe in the right column.

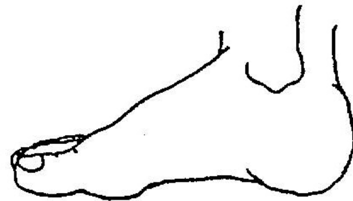
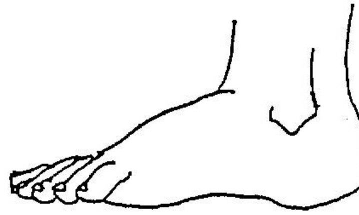
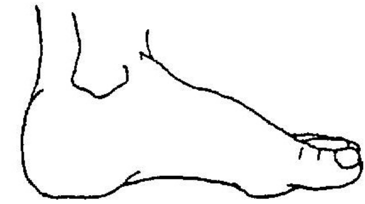
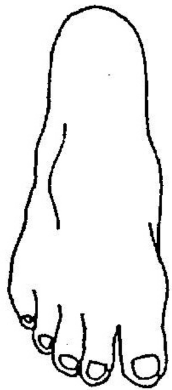
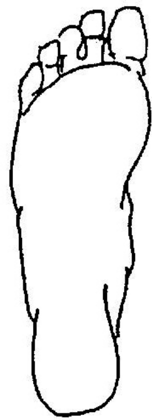
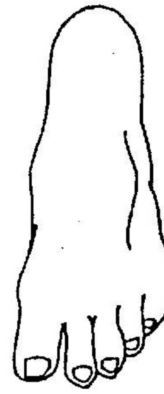
DESCRIPTION OF ONSET: Check one or more.
Congenital -- ☐ Crush ☐ Repetitive use -- ☐ Sudden onset --- ☐ Work-related ---- ☐
Fall ----------- ☐ Twist - ☐ Direct blow ------ ☐ Gradual onset--- ☐ Sports-related -- ☐
No Injury ---- ☐ Other ________________________________

BRIEFLY DRAW LOCATION OF MAIN PROBLEMS ON THE DIAGRAM ON THE NEXT PAGE.

Patient's Name ______________________________ Chart No. ______________

Date ______________

CIRCLE AREA OF SYMPTOMS (label pain, swelling, weakness, stiffness, numbness, lumps, etc.)

RIGHT		LEFT	
			
Lateral (Outside)	Medial (Inside)	Lateral (Outside)	Medial (Inside)
			
Dorsal (Top)	Plantar (Bottom)	Dorsal (Top)	Plantar (Bottom)

RIGHT

LEFT

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

Briefly describe what happened when symptoms started, **and specify your location** at onset (home, work, etc.)

____

____

____

____

____

____

PREVIOUS TREATMENT OR EVALUATIONS: NONE ☐ (If none, skip to SELF CARE)

The **FIRST** doctor/E.R./Urgent Care I saw for this problem:

Name ______________________ City ______________________

This doctor is a: Emergency Room Doctor ☐ Podiatrist ☐ Company doctor ☐

Family doctor ☐ Orthopedic surgeon ☐ Other ______________________

Date of first exam __________ **Date of last visit** __________ **# of visits** _____

Tests: X-Rays ☐ Blood Tests ☐ Nerve Tests ☐ CT scan ☐ Bone Scan ☐ MRI ☐

TREATMENT:

Steroid injections -------☐ How many _____ Date of last one _______ Helped? Yes ☐ No ☐

Anti-inflammatory pills--☐ Drug names ______________ Helped? Yes ☐ No ☐

Pain pills------------------☐ Drug names ______________ Helped? Yes ☐ No ☐

Physical therapy---------☐ Number of visits ______________ Helped? Yes ☐ No ☐

Pads/shoe modification ☐ Type ______________ Helped? Yes ☐ No ☐

Orthotics------------------☐ Type ______________ Helped? Yes ☐ No ☐

Cast ☐ or Walker Boot ☐ How long? ______________ Helped? Yes ☐ No ☐

Surgery performed------☐ Recommended surgery, did not do ☐ Helped? Yes ☐ No ☐

Other ______________________ Helped? Yes ☐ No ☐

The **SECOND** doctor I saw for this problem:

Name ______________________ City ______________________

This doctor is a: Emergency Room Doctor ☐ Podiatrist ☐ Company doctor ☐

Family doctor ☐ Orthopedic surgeon ☐ Other ______________________

Date of first exam __________ **Date of last visit** __________ **# of visits** _____

Tests: X-Rays ☐ Blood Tests ☐ Nerve Tests ☐ CT scan ☐ Bone Scan ☐ MRI ☐

TREATMENT:

Steroid injections -------☐ How many _____ Date of last one _______ Helped? Yes ☐ No ☐

Anti-inflammatory pills--☐ Drug names ______________ Helped? Yes ☐ No ☐

Pain pills------------------☐ Drug names ______________ Helped? Yes ☐ No ☐

Physical therapy---------☐ Number of visits ______________ Helped? Yes ☐ No ☐

Pads/shoe modification ☐ Type ______________ Helped? Yes ☐ No ☐

Orthotics------------------☐ Type ______________ Helped? Yes ☐ No ☐

Cast ☐ or Walker Boot ☐ How long? ______________ Helped? Yes ☐ No ☐

Surgery performed------☐ Recommended surgery, did not do ☐ Helped? Yes ☐ No ☐

Other ______________________ Helped? Yes ☐ No ☐

IF YOU SAW MORE THAN TWO DOCTORS FOR THIS PROBLEM PLEASE CHECK ☐ AND CONTINUE ON THE BACK SIDE OF THIS PAGE.

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

The **THIRD** doctor I saw for this problem:

Name ______________________________ City ______________________________

This doctor is a: Emergency Room Doctor ☐ Podiatrist ☐ Company doctor ☐

Family doctor ☐ Orthopedic surgeon ☐ Other ______________________________

Date of first exam _____________ **Date of last visit** _____________ **# of visits** _____

Tests: X-Rays ☐ Blood Tests ☐ Nerve Tests ☐ CT scan ☐ Bone Scan ☐ MRI ☐

TREATMENT:

Steroid injections -------☐ How many _____ Date of last one _______ Helped? Yes ☐ No ☐

Anti-inflammatory pills--☐ Drug names ______________________ Helped? Yes ☐ No ☐

Pain pills-------------------☐ Drug names ______________________ Helped? Yes ☐ No ☐

Physical therapy---------☐ Number of visits ____________________ Helped? Yes ☐ No ☐

Pads/shoe modification ☐ Type ____________________________ Helped? Yes ☐ No ☐

Orthotics-------------------☐ Type ____________________________ Helped? Yes ☐ No ☐

Cast ☐ or Walker Boot ☐ How long? ________________________ Helped? Yes ☐ No ☐

Surgery performed------☐ Recommended surgery, did not do ☐ Helped? Yes ☐ No ☐

Other ____ Helped? Yes ☐ No ☐

The **FOURTH** doctor I saw for this problem:

Name ______________________________ City ______________________________

This doctor is a: Emergency Room Doctor ☐ Podiatrist ☐ Company doctor ☐

Family doctor ☐ Orthopedic surgeon ☐ Other ______________________________

Date of first exam _____________ **Date of last visit** _____________ **# of visits** _____

Tests: X-Rays ☐ Blood Tests ☐ Nerve Tests ☐ CT scan ☐ Bone Scan ☐ MRI ☐

TREATMENT:

Steroid injections -------☐ How many _____ Date of last one _______ Helped? Yes ☐ No ☐

Anti-inflammatory pills--☐ Drug names ______________________ Helped? Yes ☐ No ☐

Pain pills-------------------☐ Drug names ______________________ Helped? Yes ☐ No ☐

Physical therapy---------☐ Number of visits ____________________ Helped? Yes ☐ No ☐

Pads/shoe modification ☐ Type ____________________________ Helped? Yes ☐ No ☐

Orthotics-------------------☐ Type ____________________________ Helped? Yes ☐ No ☐

Cast ☐ or Walker Boot ☐ How long? ________________________ Helped? Yes ☐ No ☐

Surgery performed------☐ Recommended surgery, did not do ☐ Helped? Yes ☐ No ☐

Other ____ Helped? Yes ☐ No ☐

The **FIFTH** doctor I saw for this problem:

Name ______________________________ City ______________________________

This doctor is a: Emergency Room Doctor ☐ Podiatrist ☐ Company doctor ☐

Family doctor ☐ Orthopedic surgeon ☐ Other ______________________________

Date of first exam _____________ **Date of last visit** ___________ **# of visits** ____ ___

Tests: X-Rays ☐ Blood Tests ☐ Nerve Tests ☐ CT scan ☐ Bone Scan ☐ MRI ☐

TREATMENT:

Steroid injections -------☐ How many _____ Date of last one _______ Helped? Yes ☐ No ☐

Anti-inflammatory pills--☐ Drug names ______________________ Helped? Yes ☐ No ☐

Pain pills-------------------☐ Drug names ______________________ Helped? Yes ☐ No ☐

Physical therapy---------☐ Number of visits ____________________ Helped? Yes ☐ No ☐

Pads/shoe modification ☐ Type ____________________________ Helped? Yes ☐ No ☐

Orthotics-------------------☐ Type ____________________________ Helped? Yes ☐ No ☐

Cast ☐ or Walker Boot ☐ How long? ________________________ Helped? Yes ☐ No ☐

Surgery performed------☐ Recommended surgery, did not do ☐ Helped? Yes ☐ No ☐

Other ____ Helped? Yes ☐ No ☐

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

FOOT AND ANKLE SURGERY: list earliest surgery first NONE ☐

1. Date ___________ Doctor ________________________ Hospital ___________________________
   Type of surgery Right ________________________ Left ______________________________
   Helped? Yes☐ No☐ Complications? (list) ____
   Other ____
2. Date ___________ Doctor ________________________ Hospital ___________________________
   Type of surgery Right ________________________ Left ______________________________
   Helped? Yes☐ No☐ Complications? (list) ____
   Other ____
3. Date ___________ Doctor ________________________ Hospital ___________________________
   Type of surgery Right ________________________ Left ______________________________
   Helped? Yes☐ No☐ Complications? (list) ____
   Other ____

SELF CARE: None ☐ Other ____
Changed shoes ☐ Trimmed calluses ☐ Store bought pads or arch supports ☐

ANTICIPATED SURGERY:
Would consider surgery if the doctor thinks it's necessary? Yes ☐ No ☐

FACTORS OF PAIN OR DISCOMFORT: check one or more.

Walking in shoes ---------------------- ☐
Walking barefooted -------------------- ☐
First getting up in the morning ------ ☐
Walking after resting or sitting ------ ☐
At rest or at night ---------------------- ☐
Being on my feet all day ---------------------- ☐
Cold, damp weather --------------------------- ☐
Walking while carrying loads ---------------- ☐
Climbing stairs or ladders -------------------- ☐
Squatting -- ☐
Other ____

FACTORS OF RELIEF: check one or more.

Staying off my feet -------------------- ☐
Elevating feet -------------------------- ☐
Applying ice ---------------------------- ☐
Rubbing my feet ----------------------- ☐
Removing shoes ------------------------------ ☐
Hanging feet over side of bed --------------- ☐
Special shoes (type__________________) ☐
Other ______________________________

FREQUENCY OF PAIN: check one or more. None ☐

Some pain is always present--------------------- ☐
Frequency of pain depends on activities ------ ☐

FREQUENCY OF SWELLING: check one or more. None ☐

Some swelling is always present--------------------- ☐
Frequency of swelling depends on activities ------ ☐

FREQUENCY OF INSTABILITY: check one or more. None ☐

(For patients with ankle problems: Instability means that the ankle feels as though it will give out, actually gives out, or "resprains.")
Walking on uneven surfaces ☐ Playing sports ☐ Type of sports? _________________________
Instability occurs several times a week ☐ a month ☐ a year ☐
Instability is becoming more frequent ☐ less frequent ☐

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

AIDS FOR WALKING: (used frequently) check one or more. None ☐
Wheelchair ☐ Crutches ☐ Cane ☐ Other ____________________

ACTIVITY LIMITATIONS

Regular Activities **Prior** To Pain /Injury (Check one or more)		**Current** Limitations: Do with difficulty (now)	Unable to do (now)
Bicycling	☐	☐	☐
Bowling	☐	☐	☐
Golfing	☐	☐	☐
Running	☐ miles/week ___ years running ___	☐	☐
Walking	☐ miles/week ___ years walking ___	☐	☐
Other sports	____________	☐	☐
House/yard work	☐	☐	☐
Usual occupation	☐	☐	☐
Other	____________	☐	☐

After walking _____ blocks or _____ minutes, I have to stop walking because of my symptoms.

Generally, over time, I'm: Better ☐ Same ☐ Worse ☐

Sports (if applicable): Current Sport __________ Position __________
Level (highschool, club, etc.) __________ Team __________ Coach __________

OTHER BODY AREAS AFFECTED BY MY FOOT/ANKLE INJURY/PROBLEM: None ☐

	R	L	How Related
Head	☐		____________
Neck	☐		____________
Low Back	☐		____________
Shoulders	☐	☐	____________
Hips	☐	☐	____________
Knees	☐	☐	____________

PREVIOUS INJURIES RELATED TO THIS PROBLEM: (same foot or ankle) NONE ☐
Date of previous injury ___/___ Describe ____________________
When present problem began was this previous problem completely resolved? Yes ☐ No ☐

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY
(General History)

GENERAL MEDICAL HISTORY

MEDICAL ILLNESSES/CONDITIONS: NONE ☐ Check as many as are applicable

Gout ☐
Psoriasis ☐
Heart disease (type)______ ☐
High blood pressure ☐
Bad circulation in feet ☐
Bad leg veins (Vericose, Phlebitis, DVT) ☐
Bleeding disorder/tendency ☐
Anemia ☐
Ankle swelling ☐
Lung disease (type, include embolus, asthma, etc.) ☐
Stomach/intestinal (type)______ ☐
Kidney disease (type)______ ☐

Bladder problems (type)______ ☐
Seizures ☐
Stroke ☐
Liver disease (hepatitis, etc.) ☐
Glaucoma ☐
Neurological (type)______ ☐
Psychiatric illness (type)______ ☐
Cancer (type)______ ☐
Thyroid disease (type)______ ☐
Hyperthermia (with anesthesia) ☐
Previous MRSA infection ☐

Arthritis, Degenerative ☐
Arthritis, Rheumatoid (Blood Test Postive) ☐ Age at onset ___ Years
Arthritis, Other (Lupus,etc.) (type)______ ☐ Age at onset ___ Years
Diabetes ☐ Age at onset ___ Years Insulin Yes ☐ No ☐
Other ______

WOMEN ONLY:
Not pregnant ☐ Possibly pregnant ☐ Definitely pregnant ☐
Pre Menopausal ☐ Post Menopausal ☐

CURRENT MEDICATIONS: NONE ☐

Name of medication (Include Insulin)	Dose	Frequency	Duration of use
______	______	______	Months ____ Years ____
______	______	______	Months ____ Years ____
______	______	______	Months ____ Years ____
______	______	______	Months ____ Years ____
______	______	______	Months ____ Years ____
______	______	______	Months ____ Years ____
______	______	______	Months ____ Years ____

ASPIRIN (Anacin, Empirin)? Yes ☐ more than 10 tablets/month Yes ☐ less than 10 tablets/month No ☐

PAST STEROIDS: I have taken steroid pills in the past. Yes ☐ No ☐

HAVE YOU RECEIVED A HEPATITIS B VACCINATION? Yes ☐ No ☐ Unsure ☐

LAST TETANUS IMMUNIZATION? Within past 5 years ☐ More than 5 years ago ☐

ALLERGIES: NONE ☐
(include medicine, adhesive tape, iodine products, xray dyes, foods, etc.)

Medication, etc.	Reactions			
______	Rash ☐	Anaphylaxis ☐	Nausea ☐	Other ______
______	Rash ☐	Anaphylaxis ☐	Nausea ☐	Other ______
______	Rash ☐	Anaphylaxis ☐	Nausea ☐	Other ______
______	Rash ☐	Anaphylaxis ☐	Nausea ☐	Other ______
______	Rash ☐	Anaphylaxis ☐	Nausea ☐	Other ______

Non Medications ______

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY
(General History)

OTHER ORTHOPAEDIC PROBLEMS: None ☐

Back ☐		Shoulder	R ☐	L ☐	Arm	R ☐	L ☐	Hand	R ☐	L ☐
Neck ☐		Hip	R ☐	L ☐	Knee	R ☐	L ☐	Leg	R ☐	L ☐

Describe other
orthopaedic problems ____

____

____

____

____

OPERATIONS: (other than foot and ankle) NONE ☐

1. Date ___/___ Type ______________________________
   Complications (Including anesthetic)? ______________________________
2. Date ___/___ Type ______________________________
   Complications (Including anesthetic)? ______________________________
3. Date ___/___ Type ______________________________
   Complications (Including anesthetic)? ______________________________
4. Date ___/___ Type ______________________________
   Complications (Including anesthetic)? ______________________________

OTHER HOSPITALIZATIONS: (other than for surgery or childbirth) NONE ☐

1. Date ___/___ Diagnosis ______________________________
2. Date ___/___ Diagnosis ______________________________
3. Date ___/___ Diagnosis ______________________________

TOBACCO/ALCOHOL/RECREATIONAL DRUG USE/HIV RISK FACTORS:

☐ I have never smoked. ☐ I am a smoker. (____ packs per day) # Years Smoking ____
☐ I have been a smoker and I stopped smoking in (year) ______

☐ I do not use alcohol.
☐ I drink alcohol occasionally.
☐ I drink 3 or more alcoholic beverages per day, several times a week.

FAMILY HISTORY: Do/did any "blood relatives" have any of the following? None to list ☐

Disease		Relationship	Comment
Cancer -------------------------------------	☐	__________	______________________________
Heart disease --------------------------	☐	__________	______________________________
Diabetes ---------------------------------	☐	__________	______________________________
Arthritis ----------------------------------	☐	__________	______________________________
Bone disease --------------------------	☐	__________	______________________________
Foot or ankle problem-----------------	☐	__________	______________________________
Hyperthermia (with anesthesia) ----	☐	__________	______________________________
Other -------------------------------------	☐	__________	______________________________

SOCIAL HISTORY:

Home members
- ☐ Live alone
- ☐ Live with family members (relationship(s)) ____________________________________
- ☐ Other ____

Height __________ Weight ____________ Shoe Size ________ Width ________

Right handed ☐ Left handed ☐

PLEASE USE THIS SPACE FOR ADDITIONAL PERTINENT INFORMATION OR SPECIFIC QUESTIONS YOU WISH TO ASK.

____

Signature of patient, guardian or witness

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY
(Work Injury History)

IF INJURED AT WORK, please give the following information:

Name of company ______________________________

City ______________________________

Length of time with company at time of injury ______________________________

Your usual job title ______________________________

Job description (Patient's usual job / activities) ______________________________

How many hours do/did you stand and/or walk in 8-hour day? __________

Carry loads? Never ☐ Occasionally (1/3) ☐ Frequently (2/3) ☐

Usual weight of load: (range) __________

Climb? Never ☐ Occasionally (1/3) ☐ Frequently (2/3) ☐

Use foot controls? Never ☐ Occasionally (1/3) ☐ Frequently (2/3) ☐

How long have/had you been doing this type of work? ________

What was your job activity at time of injury? ______________________________

Your specific location at time of injury? ______________________________

Was your supervisor notified of the injury? Yes ☐ No ☐

Relationship with supervisor at time of injury: Good ☐ Fair ☐ Poor ☐

Level of job satisfaction: High ☐ Average ☐ Low ☐

PREVIOUS WORK INJURIES: None ☐

	Date Injured	Diagnosis (note right or left if applicable)	Time off Work
1.	___/___	______________________________	__________
2.	___/___	______________________________	__________
3.	___/___	______________________________	__________
4.	___/___	______________________________	__________

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY
(Work Injury History)

CURRENT WORK STATUS:

1. Are you now working? Yes ☐ No ☐

   (If "no," skip to question #5)

2. Are you doing the same type of work as before? Yes ☐ No ☐

3. If you are doing different work, please explain: ____________________

4. Did you miss time from work due to the injury? Yes ☐ No ☐

   (If "no," skip to question #6)

5. If you missed work, please indicate the periods of missed work.

   From (date) __________ to __________

   From (date) __________ to __________

   From (date) __________ to __________

6. If you have you been on work restrictions, please indicate the periods. None ☐

   From (date) __________ to __________. Type of restriction ____________________

   From (date) __________ to __________. Type of restriction ____________________

   From (date) __________ to __________. Type of restriction ____________________

7. If you are NOT working now, when did you last work? Date ___________ Not applicable ☐

   - If you are NOT working now, is it because of this injury? Yes ☐ No ☐ Not applicable ☐

     If "No," list reason for not working. ____________________

   - Is your old job still available Yes ☐ No ☐ Not applicable ☐

Do you have an attorney involved with this problem? Yes ☐ No ☐

Name of Attorney: ____________________ Phone ____________________

Address: ____________________City ____________________ State ___ ZIP ______________

Date of attorney acquisition ___________

Reason for attorney acquisition ____________________