Dear Patient,

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

<u>Please fill out the interval visit forms</u>. Describe your new problem or current symptoms of a persistent problem. If you have a persistent problem that was previously treated in this office, note the treatment or evaluation you have received <u>since</u> your last visit here.

If your last visit was over 6 months ago, you will be given a copy of your previous general medical history. Add or remove information as appropriate, using the red pen. Please date the copy.

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

Thank you for your assistance. We look forward to seeing you again.

Sincerely,

Ronald W. Smith, M.D.

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	Indicate **Most** Severe*
Leg	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Leg
Ankle	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Ankle
Heel	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Heel
Bunion	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Bunion
Top of arch	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Top of arch
Sole of arch	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Sole of arch
Side of the foot	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Side of the foot
Ball of foot	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Ball of foot
Great toe	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ Great toe
2nd toe	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ 2nd toe
3rd toe	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ 3rd toe
4th toe	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ 4th toe
5th toe	R ☐	L ☐	# __ weeks	# __months	# __ years	_____	☐ 5th toe

* 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 _____

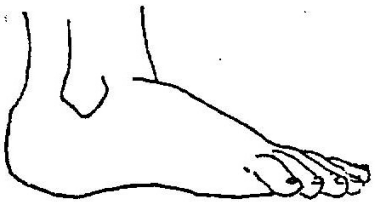
BRIEFLY DRAW LOCATION OF MAIN PROBLEMS ON THE DIAGRAM ON THE NEXT PAGE.

Patient's Name _____ Chart No. _____

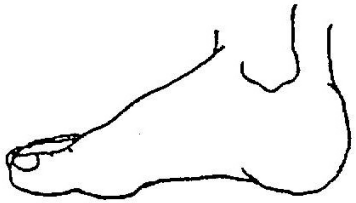
Date _____

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

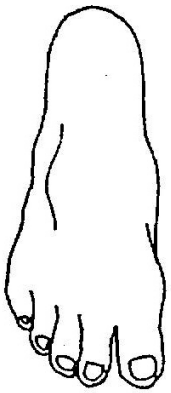
RIGHT



Lateral
(Outside)



Medial
(Inside)

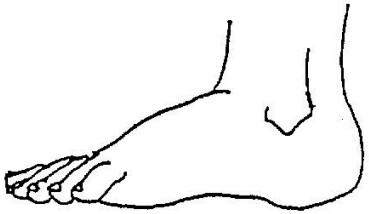


Dorsal
(Top)

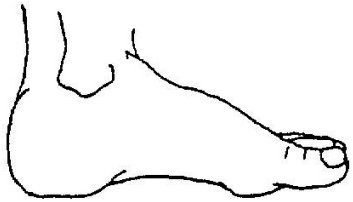
RIGHT

Plantar
(Bottom)

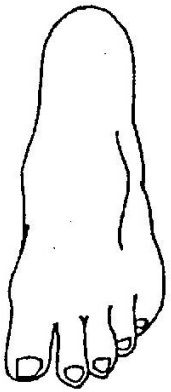
LEFT



Lateral
(Outside)



Medial
(Inside)



Dorsal
(Top)

LEFT

Plantar
(Bottom)

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 ☐

SELF CARE: None ☐ Other _____

Changed shoes ☐ Trimmed calluses ☐ Store bought pads or arch supports ☐