

# MIDWEST ORTHOPEDICS FOOT & ANKLE, PC

Date \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_ Name of Doctor or Person who referred you? \_\_\_\_\_

## **CHIEF COMPLAINT:**

What are we seeing you for today (i.e. right heel pain, left knee pain, both hips pain)? \_\_\_\_\_

## **HISTORY OF PRESENT ILLNESS:**

Was this an injury or accident or did it start gradually? \_\_\_\_\_

If this is an injury or accident:

In what state did the injury or accident occur? \_\_\_\_\_

Where did the injury occur (i.e. work, home, church)? \_\_\_\_\_

How did it happen? \_\_\_\_\_

When did it occur? \_\_\_\_\_

Where were you initially (i.e. St Joseph's Emergency Room)? \_\_\_\_\_

How were you treated (i.e. x-rays, splint, pain meds, crutches, ice elevation, other \_\_\_)?  
\_\_\_\_\_

If this came on gradually, or since the injury, how have you been treated? \_\_\_\_\_  
(i.e. x-rays, inserts, shots, physical therapy, non-steroidal medication)  
\_\_\_\_\_

Have any special test been done?

\_\_\_\_ Bone scan, results: \_\_\_\_\_

\_\_\_\_ MRI, results: \_\_\_\_\_

\_\_\_\_ CT scan, results: \_\_\_\_\_

How long has this been going on (i.e. 1 wk, 3 mo., 4 yrs.)? \_\_\_\_\_

Do you have pain daily? Yes/No      Does it cause you to limp? Yes/No

Does it keep you from doing things you enjoy? Yes/no

Such as (i.e. golfing, walking)? \_\_\_\_\_

When does it hurt the most (i.e. first thing in the morning, throughout the day, at night)? \_\_\_\_\_

Do you have \_\_\_ swelling, \_\_\_ locking or catching, \_\_\_ giving way? (Check all that apply)

Does it wake you up at night or keep you awake? \_\_\_\_\_

What aggravates it? \_\_\_ standing, \_\_\_ Walking, \_\_\_ sitting, other \_\_\_\_\_

What makes it feel better? \_\_\_ Elevation, \_\_\_ ice, \_\_\_ wraps, \_\_\_ staying off it, other \_\_\_\_\_

Have you had any previous surgeries or injuries of this body part? Yes/No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you do any regular exercise? Yes/No, If you please explain:

\_\_\_\_ stair stepper, stair master

\_\_\_\_ walking: How often? \_\_\_\_\_ How far? \_\_\_\_\_

\_\_\_\_ running: How often? \_\_\_\_\_ How far? \_\_\_\_\_

Physician Signature: \_\_\_\_\_