



Foot and Ankle Problem History Form: Please Print and Fill Out One Form of This Type for Each Unique Problem
This is my Foot or Ankle Problem Number: (Please Circle One) 1 2 3 4 5 6 7 8 9 10

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date \_\_\_\_\_

Who referred you to Aloha Foot and Ankle? \_\_\_\_\_

PLEASE DESCRIBE YOUR PRIMARY FOOT/ANKLE CONDITION [ ] RIGHT [ ] LEFT [ ] BOTH (Please use appropriate level of detail)

Blank lines for describing the primary foot/ankle condition.

DESCRIPTION OF ONSET (Check any and all that apply, detail is important!) When did this problem begin? Date \_\_\_\_\_

- [ ] Congenital [ ] Crush [ ] Repetitive use [ ] Sudden onset [ ] Slip/Fall [ ] Sport related [ ] Twist [ ] Direct blow [ ] Gradual onset [ ] Other

Is this problem work related? [ ] Yes [ ] No \* If Yes, please fill out Worker's Compensation History Forms and bring copies of all related medical history, any laboratory results, imaging studies or other pertinent information with you.

PAIN SCALE (Circle) ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

IS YOUR PAIN WORSE IN THE: Morning? [ ] Evening? [ ] All Day? [ ]

QUALITY OF PAIN [ ] Sharp [ ] Dull [ ] Radiating [ ] Burning [ ] Aching [ ] Cramping [ ] Continuous [ ] Intermittent [ ] Other \_\_\_\_\_

WHAT IMPROVES YOUR PAIN? \_\_\_\_\_ WHAT WORSENS YOUR PAIN? \_\_\_\_\_

If you have had prior treatment, please bring all imaging films to your first appointment, and if you have a prior surgical failure, or post-traumatic deformity, please bring pertinent medical records such as surgical reports or discharge summaries from hospital admissions.

Previous X-rays? \_\_\_\_\_ Date Taken? \_\_\_\_\_ [ ] Yes [ ] No Previous MRI? \_\_\_\_\_ Date Taken? \_\_\_\_\_ [ ] Yes [ ] No
Previous CT Scan? \_\_\_\_\_ [ ] Yes [ ] No Previous Labs? \_\_\_\_\_ [ ] Yes [ ] No

PREVIOUS TREATMENT? (Including Self-Care & Surgery) [ ] Yes [ ] No If yes, check appropriate box below

- [ ] Steroid injection How many? \_\_\_\_\_ Date of last injection \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Anti-inflammatory pills Name of medication \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Pain Pills Name of medication \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Orthotics [ ] OTC Inserts Are you currently using them? [ ] Yes [ ] No Helped? [ ] Yes [ ] No
[ ] Cast or other Immobilization How Long? \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Surgery Date \_\_\_\_\_ What Type? \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Surgery Date \_\_\_\_\_ What Type? \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Surgery Date \_\_\_\_\_ What Type? \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Other \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Other \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Other \_\_\_\_\_ Helped? [ ] Yes [ ] No
[ ] Other \_\_\_\_\_ Helped? [ ] Yes [ ] No

Please mark areas of pain, injury, or problem in the appropriate areas on the diagrams below.

