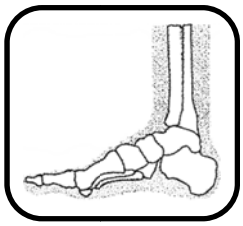
MISSOULA Bone & Joint & Surgery Center



## FOOT & ANKLE FORM

**Date:** _____ **Name:** _____

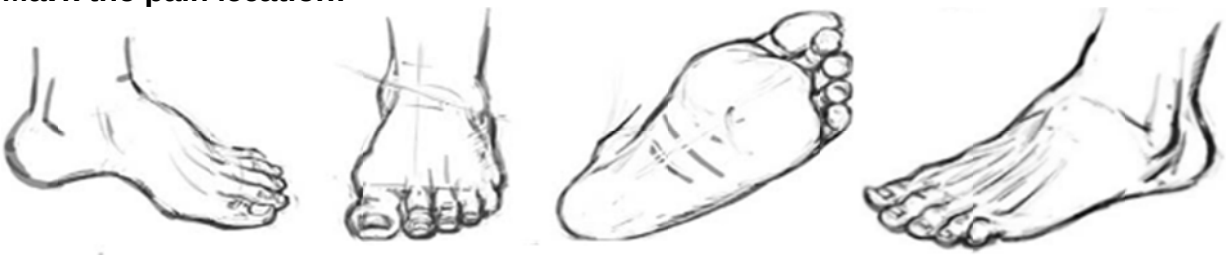
**Age:** _____ **Occupation:** _____ **Referring Physician:** _____

**Complaint:** □ Foot □ Ankle

□ Left □ Right □ Both

□ Pain □ Instability □ Deformity □ Other: _____

**Mark the pain location:**



Inside Top Bottom Outside

**How did your problem start?**

_____

**When did it start?** Date: _____ □ Uncertain

**How long have you had symptoms?** □ Days □ Weeks □ Months □ Years

**Overall, things are getting:** □ Better □ Worse □ Same

**Have you noticed a change in your foot shape?** □ Yes □ No

**How would you describe your pain?** □ None □ Dull/Achy □ Sharp/Stabbing □ Burning
□ Other: _____

| | | |
|---|---|---|
| **Do you have swelling?** | □ Yes | □ No |
| **Do you have bruising/discoloration?** | □ Yes | □ No |
| **Do you have numbness/tingling?** | □ Yes | □ No |
| **When is your problem present?** | □ Always | □ On/off |

**What shoes are most comfortable?** □ Athletic □ Flats □ Mild heel □ High top
□ Sandals □ Other: _____

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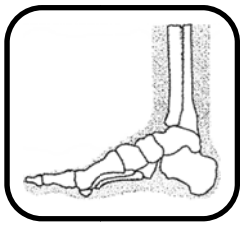

## FOOT & ANKLE FORM

**How does the following affect your problem?**

| | Worse | Better | Unaffected |
|---|---|---|---|
| Rest | □ | □ | □ |
| First Morning Steps | □ | □ | □ |
| Midmorning | □ | □ | □ |
| Afternoon/Evening | □ | □ | □ |
| Night | □ | □ | □ |
| Standing | □ | □ | □ |
| Running | □ | □ | □ |
| Evening | □ | □ | □ |
| Barefoot | □ | □ | □ |
| Walking | □ | □ | □ |

**How far can you walk?** □ Less than 1 block □ 2 to 5 blocks □ Greater than 6 blocks □ Greater than 1 mile

**Do you routinely use any of the following?** □ Cane □ Crutches □ Wheelchair □ None

**Do you walk with a limp?** □ Yes □ No

| **Which of the following have you tried?** | **Did it help?** |
|---|---|
| □ Physical therapy | □ Yes □ No |
| □ Custom orthotics (shoe inserts) | □ Yes □ No |
| □ Soft ankle brace | □ Yes □ No |
| □ Hard ankle brace (ankle-foot orthosis) | □ Yes □ No |
| □ Injections | □ Yes □ No |
| How many? _____ | |
| □ Other: _____ | □ Yes □ No |

**Please list all previous surgery on your foot/ankle:**

_____

_____

**Check any of the following you have had:**

□ Postoperative infection □ Postoperative wound complication
□ Deep venous thrombosis □ Reaction to anesthesia

**Check any of the following medical conditions you have:**

□ Rheumatoid arthritis □ Diabetes
□ Peripheral vascular disorder □ Blood clotting disorder

**Check any of the activities you regularly do:**

□ Walking □ Gym □ Cycling □ Golf □ Running – miles/week _____
□ Other: _____