FOOT AND ANKLE INJURY QUESTIONNAIRE JOHN A. PAPA, M.D.

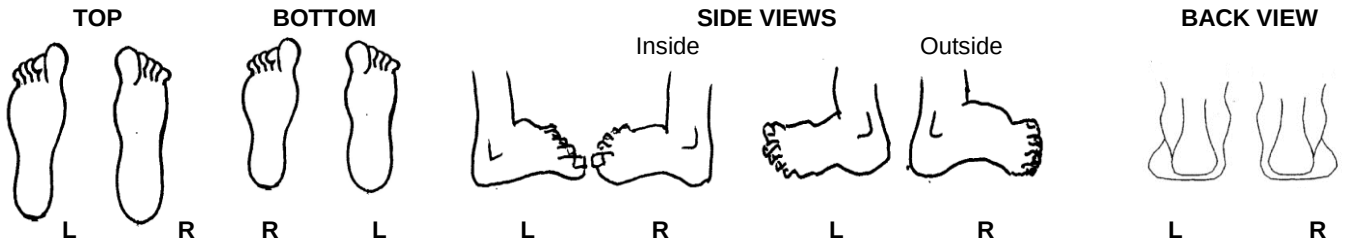
Today's Date: _____ Patient's Name: _____ Age: _____ JOC #: _____
Name Preferred to be called: _____ Have you ever seen Dr. Papa before: Y / N If yes, when ?: _____
Has a member of your family seen Dr. Papa?: _____ If yes, who: _____
1. Name of Primary Care Physician: _____ **2. Referred By**: _____
3. Cardiologist: _____ **4. Rheumatologist**: _____
5. Please describe the primary problem for which you are seeking evaluation:

_____
_____
6. How long have you had this problem (pain)? _____
7. Seen previously for this problem: ☐ Yes ☐ No By Whom: ☐ Walk-In Clinic; ☐ ER; ☐ Primary Care Physician (name(s): _____; ☐ Podiatrist (name(s) _____
☐ Orthopaedist (name(s) _____
8. Previous testing: ☐ X-rays ☐ MRI ☐ CT scan ☐ Blood tests
9. What size shoe do you wear: _____
10. What treatment have you tried (Please **circle** all that apply)

ICE/HEAT	SPLINT/BRACE	ELEVATION
CAST	INJECTION(S) if yes, how many _____	
ORTHOTICS (over the counter/prefab) / ORTHOTICS (custom)		
MEDICATION (list) _____	Surgery (describe) _____	

ACCUPUNCTURE
SPECIAL SHOES (Describe _____)
WALKING BOOT

11. Please circle/mark where you have the most pain or location of the problem:



12. When is the pain present? (**circle** all that apply)
Only when standing or walking
Only at rest, sitting or lying
Constant

13. What makes the pain worse? (**circle** all that apply)
Exercise
Shoes: All/Tennis/Athletic/Dress/Sandals
Barefoot
Specific activity _____

14. Quality of pain? (**circle** all that apply)
Aching
Throbbing
Sharp/stabbing
Burning
Dull

15. What helps pain: (describe)
_____

16. Do you have pain at night: ☐ Yes ☐ No
If yes, does it interfere with ability to sleep: ☐Yes☐No

17. Do you now have or have you ever had any of these problems?

Diabetes	☐ Yes	☐ No	If yes, how many years___
Ulcers or sore on your feet	☐ Yes	☐ No	If yes, when_____
Infection of your foot or ankle	☐ Yes	☐ No	If yes, when_____
Circulation problems	☐ Yes	☐ No	If yes, name of vascular surg _____
Numbness in your feet	☐ Yes	☐ No	If yes, is it occasional / constant (**circle** one) Toes: Which ones _____ Feet: L / R / Both
Back Pain	☐ Yes	☐ No	
Sciatica	☐ Yes	☐ No	
Osteoporosis-major loss bone strength	☐ Yes	☐ No	
Osteopenia-mild loss bone strength	☐ Yes	☐ No	
Rheumatoid Arthritis	☐ Yes	☐ No	
Gout	☐ Yes	☐ No	
Lupus	☐ Yes	☐ No	
DO YOU SMOKE?	☐ Yes	☐ No	
Psoriatic Arthritis	☐ Yes	☐ No	
Do you have a pacemaker	☐ Yes	☐ No	
Do you have a defibrillator	☐ Yes	☐ No	
Are you taking any blood thinners	☐ Yes	☐ No	If yes, name(s)_____ _____
Are you taking any weight loss medication	☐ Yes	☐ No	

PAIN SEVERITY (CIRCLE ONE)

AT BEST:	0	1	2	3	4	5	6	7	8	9	10
AT WORST:	0	1	2	3	4	5	6	7	8	9	10