

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) _____)

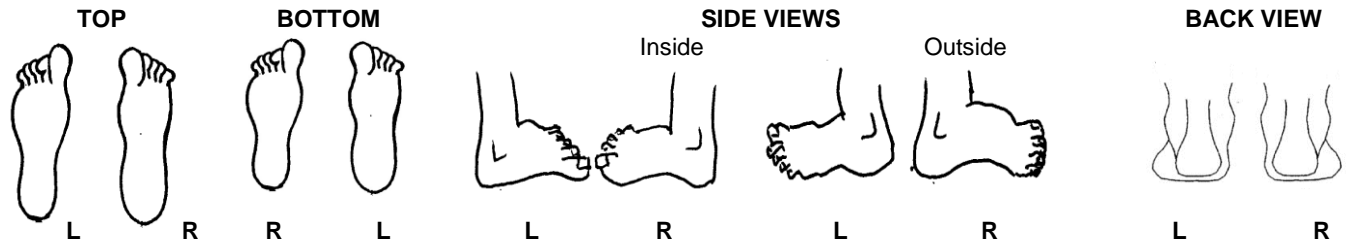
8. Previous testing: X-rays MRI CT scan Blood tests

9. What size shoe do you wear: _____

10. What treatment have you tried (Please circle all that apply)

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

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