

Foot & Ankle Orthopaedic Patient Questionnaire

Date: _____

Name: _____ Male Female

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ lbs.

Mailing Address: _____

Referring

Physician: _____ Address: _____

Primary

Care: _____ Address: _____

What is your chief complaint for seeing the doctor today?

How long has this problem (pain) been present?

Has the problem (pain) worsened recently? No Yes

If yes, how recently? _____

What would you say started the pain—exercise, fall, accident, etc...?

Location of the pain: _____

How would you describe the pain? Sharp Burning Dull Aching

Please rate the severity of your pain: Mild Moderate Severe

Does anything help with easing this pain? No Yes If yes, please give

example: _____

Please check any treatments that you have tried below and the result of this treatment for your pain:

Physical Therapy/Exercise _____

Massage/Ultrasound _____

Steroid Injections _____

Cast _____

Walker Boot _____

Off the shelf brace _____

Custom made brace _____

Off the shelf shoe insert _____

Custom molded shoe insert _____

Other _____

Family History

Family Member	Alive	Deceased	Age	Health status or cause of death
Mother's grandmother				
Father's grandmother				
Mother's grandfather				
Father's grandfather				
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				

Social History (Check all that apply)

Marital Status: Married Single Co-Habituating Divorced Widowed

Work Status: Employed Unemployed Retired Disabled Other

Current or past occupation: _____ How Long? _____

Do you have children? Yes No How Many: _____ Boys _____ Girls

Please choose your current living situation: Alone Spouse Significant Other
 Children Roommate Other _____

Please choose which of the following describes your tobacco use: Never Cigarettes
 Cigar Pipe Chew/Smokeless Tobacco

_____ Packs per day for _____ Years (Total) Quit _____ Years Ago

Please choose which of the following best describes your alcohol use: Never Rare
 Social Frequently (more than twice per week) Alcoholic Recovering Alcoholic

Please indicate any recreational drug use: None In Past Currently

Types of drugs: _____

As a result of your problem, have you filed either of the following?

Lawsuit Workers' Compensation Claim

Review Of Systems

Do you suffer from problems with any of the following:

Constitutional:

Fever Yes No
Chills Yes No
Appetite Loss/Weight Loss Yes No

Ear, Nose and Throat:

Hearing Loss Yes No
Hoarsness Yes No

Respiratory

Emphysema Yes No
Asthma Yes No
Lung Disease Yes No
Pneumonia Yes No
Tuberculosis Yes No

GU

Kidney Failure Yes No
Kidney Stones Yes No

Musculoskeletal

Fractures Yes No
Osteoarthritis Yes No
Rheumatoid Arthritis Yes No
Osteoporosis Yes No
Gout Yes No

Endocrine

Diabetes Yes No
Controlled with insulin Yes No N/A
Controlled with oral meds Yes No N/A
Please check any glandular problem which apply
 Thyroid Adrenal Pituitary

Hematology/Lymphatic

Blood clot in leg Yes No
Blood clot in lung Yes No
Bleeding Disorder Yes No

Eyes:

Blurred Vision Yes No
Vision Loss Yes No
Do you wear corrective lenses? Yes No

Cardiovascular

Heart Attack Yes No
Heart Failure Yes No
Stroke Yes No
High Blood Pressure Yes No
Poor Circulation Yes No

GI

Stomach Ulcers Yes No
Hiatal Hernia Yes No
Gastric Reflux Yes No
Hepatitis Yes No
Cirrhosis Yes No

Skin/Integumentary

Rash Yes No
Hives Yes No
Eczema Yes No

Neurological

Neuropathy (loss of feeling) Yes No
If yes, where _____
Seizure Yes No

Psychiatric

Depression Yes No
Poor Sleep Yes No
Anxiety Yes No

Anemia Yes No
HIV/AIDS Yes No

Foot and Ankle Ability Measure (FAAM) Activities of Daily Living Subscale

Please answer **every question** with **one response** that most clearly describes your condition within the past week. If the activity in question is limited by something other than your foot or ankle, please mark this as **not applicable (N/A)**

<u>Activity:</u>	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Standing						
Walking on even ground						
Walking on even ground without shoes						
Walking up hills						
Walking down hills						
Going up stairs						
Going down stairs						
Walking on uneven ground						
Stepping up and down curbs						
Squatting						
Coming up on your toes						
Walking initially--first steps						
Walking 5 minutes or less						
Walking approximately 10 minutes						
Walking 15 minutes or greater						

Because of your **foot and ankle** how much difficulty do you have with:

<u>Activity:</u>	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
<u>Home Responsibilities</u>						
<u>Activities of Daily Living</u>						
<u>Personal Care</u>						
<u>Light to Moderate Work (standing/walking)</u>						
<u>Heavy Work (push/pulling, climbing, carrying)</u>						
<u>Recreational Activity</u>						

How would you rate current level of function during your usual activities of daily living on a scale of 0 to 100; with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual daily activities?

_____ %

Foot and Ankle Ability Measure (FAAM) Sports Subscale

Because of your **foot and ankle**, how much difficulty do you have with each of the following:

Activity:	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable To Do	N/A
Running						
Jumping						
Landing						
Starting and Stopping Quickly						
Cutting/Lateral Movements						
Low Impact Activities						
Ability to perform activity with your normal technique						
Ability to participate in your desired sport for as long as you would like						

How would you rate your current level of function during your **sports related** activities from 0 to 100; with 100 being your level of function prior to your foot or ankle problem and 0 being the inability to perform any of your usual activities.

_____ %

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I have read and confirmed the above information with the patient.	
Physician: _____	MD Date _____
Physician: _____	MD Date _____
Physician: _____	MD Date _____
Physician: _____	MD Date _____