



FOOT & ANKLE QUESTIONNAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Occupation _____ Gender: Male Female Other

HISTORY

Which foot/ankle is causing the problem? Right Left Both

Main reason for your visit: _____

How long has this problem existed? _____

What is the most disabling aspect of the problem? _____

Is the problem related to an accident, job, sport, etc.? Yes No If yes, please describe _____

What makes the problem better? _____

What makes the problem worse? _____

How does your problem affect your exercise program, job, or daily activities? _____

What kind of trouble are you having with shoes? (i.e. buying, wearing, modifying, etc.) _____

What style or type of shoe is most comfortable for you? _____

TREATMENT & MEDICATIONS

What type of orthosis (i.e. arch supports, inserts, etc.) have you tried? _____

Have any of these helped the problem? Yes No

Have you used any medications for the problem? Yes No If yes, please list below.

Name of Medication	Dose	Frequency

Have any of the above medications helped the problem? Yes No If yes, please list which one _____

Please list the names of other health care providers you have seen for this problem or the podiatrist that referred you:

Physician	Specialty	City	Treatments

Please list any past surgeries related to your problem:

Surgery	Physician	When

OTHER COMMENTS _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____