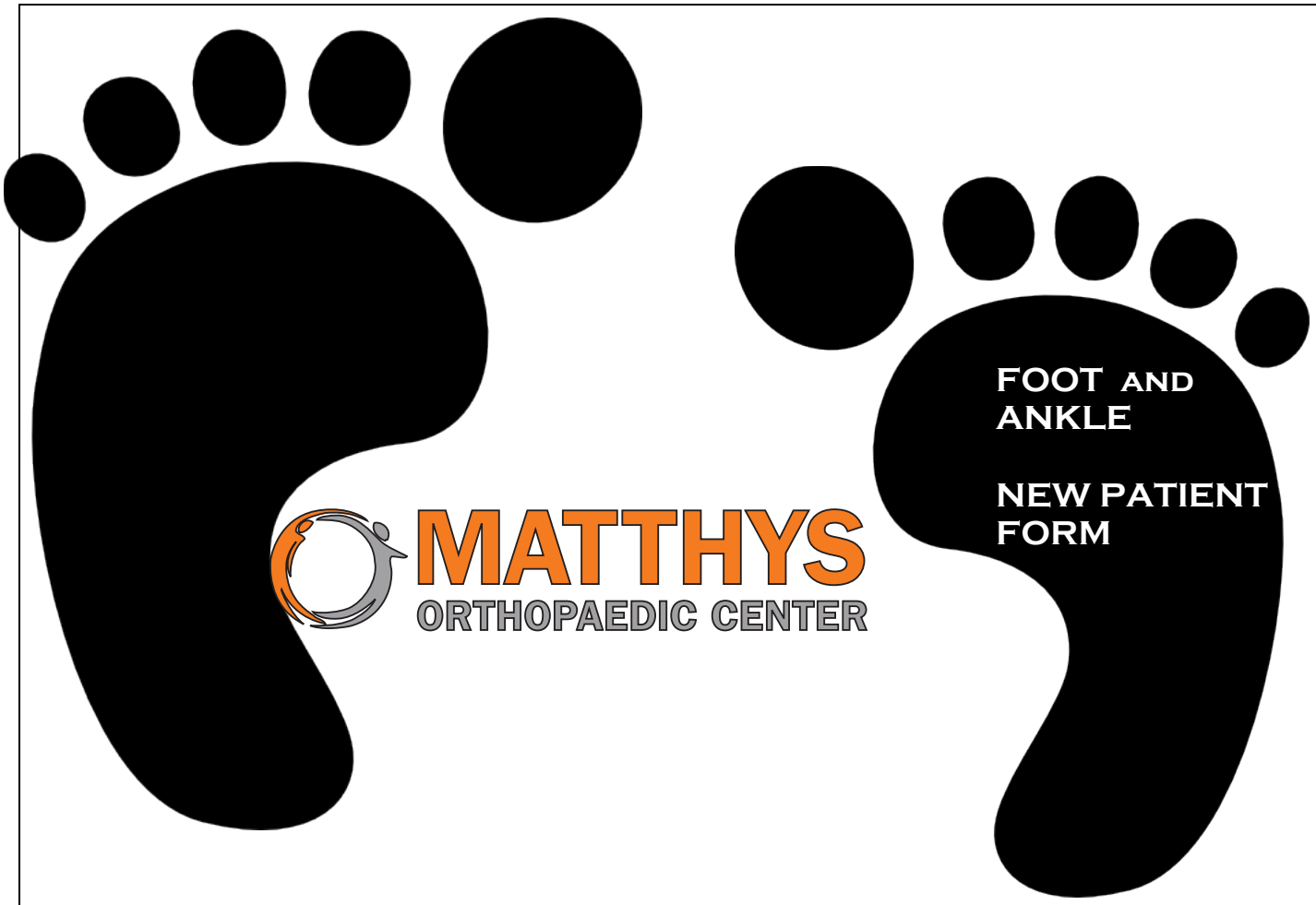


_____

PATIENTS NAME

_____/_____/_____

TODAY'S DATE

Thank you in advance for completing this questionnaire. This should take approximately 40 minutes to fill out. The purpose of these questions is to:

1. provide more effective and efficient health care.

2. evaluate the outcomes of different types of treatment and therefore allow doctors to provide the highest quality of care.

3. Comply with Insurance Company standards and requirements.

The information that you provide will help us better understand your general health and specific problems related to the conditions of the bone and muscle.

This is a confidential document.

HOW DID YOU HEAR ABOUT Matthys Orthopaedic Center (M.O.C.)?

- ☐ Newspaper
- ☐ Internet
- ☐ Billboard
- ☐ Phone Book/Yellow pages
- ☐ Mailer
- ☐ Another patient
- ☐ I am already a patient of Dr. Matthys'
- ☐ Another Doctor referred me
- ☐ Other:_____

NAME OF REFERRING DOCTOR	**City and State of Referring Doctor**
NAME OF FAMILY DOCTOR (if different)	**City and State of Family Doctor**

TODAY'S DATE

		-			-		

☐M ☐F

AGE

CURRENT EMPLOYMENT STATUS:

- ☐ Full time, secretarial or administrative type work
- ☐ Full time, with minimal lifting/bending and climbing/walking (eg. Truck driver)
- ☐ Full time, with frequent lifting/bending and climbing/walking (eg. Carpenter)
- ☐ I am on modified duty because of today's problem
- ☐ I am on modified duty because of another unrelated problem.
- ☐ Part- Time
- ☐ Student
- ☐ Retired
- ☐ Unemployed
- ☐ Disabled. Explain cause/reason for disability:

JOB TITLE/OCCUPATION:

EMPLOYER:

WHICH ANKLE or FOOT IS BOTHERING YOU?

☐ RIGHT ☐ LEFT ☐ BOTH

I AM:

- ☐ RIGHT Hand Dominant
- ☐ LEFT Hand Dominant
- ☐ use both hands equally

HOW LONG HAVE YOU HAD THESE SYMPTOMS?

- ☐ No current symptoms
- ☐ Less than one week
- ☐ Less than 2 months
- ☐ 2- 6 months
- ☐ 6 months to 1 year.
- ☐ 1 year to 3 years
- ☐ 3 years to 5 years
- ☐ greater than 5 years

IF THERE WAS AN ACCIDENT, PLEASE DESCRIBE HOW IT HAPPENED?

_____

_____

_____

DATE of accident or onset of symptoms:

		-			-		

PLEASE DESCRIBE YOUR CURRENT PROBLEM?

☐This is a **NEW** injury. I have never had problems with my ELBOW or HAND

☐The symptoms **started slowly** and have progressively worsened.

☐ I have had this problem for **many years** and the symptoms have stayed the same

☐This is a **re-injury**. Treatment was received in the past and was better until a new injury occurred.

IS THIS IS WORKMAN'S COMP CASE?

☐ yes ☐ no

HAVE YOU SEEN ANOTHER ORTHOPAEDIC DR. FOR YOUR SYMPTOMS?

☐ yes ☐ no

HAVE YOU CONSULTED A LAWYER ABOUT TODAY'S PROLEM?

☐ yes ☐ no

COMPARED TO 2 MONTHS AGO, HOW WOULD YOU RATE YOUR SYMPTOMS?

- ☐ No current symptoms
- ☐ Much Better
- ☐ Little Better
- ☐ the same
- ☐ Little Worse
- ☐ Much Worse

WHAT MAKES YOUR PAIN <u>WORSE</u>?

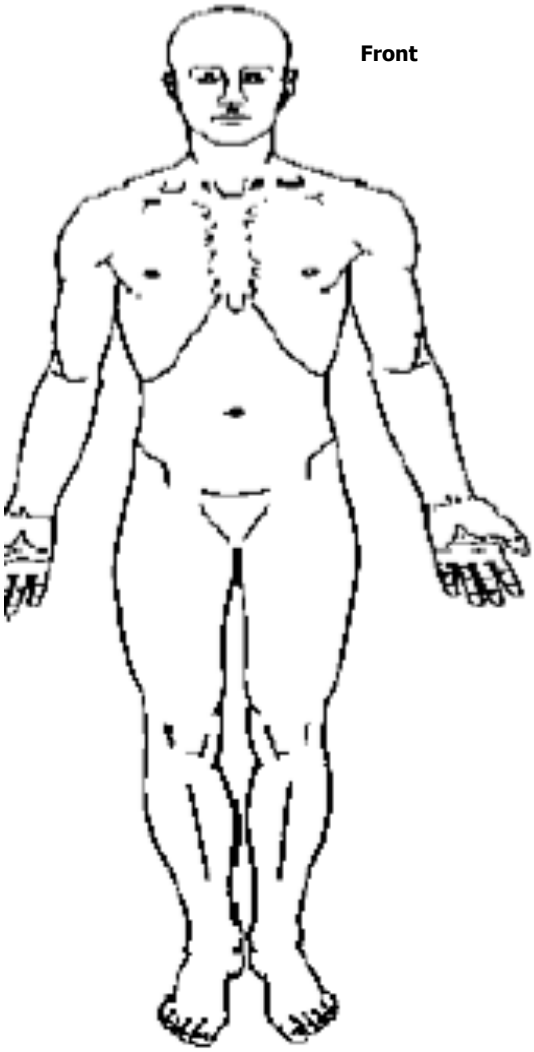
- ☐ OVERHEAD WORK
- ☐ SPORTS or RECREATIONAL ACTIVITY
- ☐ SLEEPING
- ☐ Other:_____

WHAT MAKES YOUR PAIN <u>BETTER</u>?

- ☐ MY PAIN IS LESS WHEN I AM ACTIVE
- ☐ MY PAIN IS LESS IF I REST IT
- ☐ MEDICATION
- ☐ THERAPY
- ☐ INJECTIONS
- ☐ Other:_____

PLEASE MARK THE *BODY DIAGRAM* BELOW WITH AN "X" FOR SHARP PAIN or an "O" FOR NUMBNESS. MARK ALL AREAS THAT APPLY.

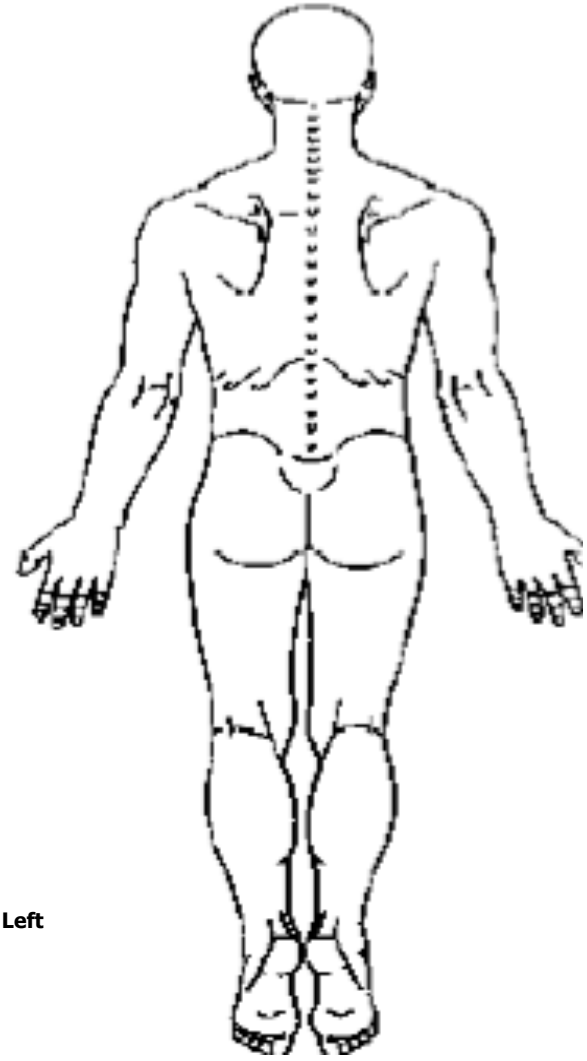
Front



Right

Left

Back



WHERE IS THE PAIN? PLEASE CHECK (X) ALL THOSE THAT APPY:

- ☐ KNEE
- ☐ CALF
- ☐ BACK OF ANKLE
- ☐ FRONT OF ANKLE
- ☐ OUTER PART OF ANKLE
- ☐ INNER PART OF THE ANKLE
- ☐ HEEL BONE
- ☐ INSTEP
- ☐ BALL OF THE FOOT
- ☐ TOE(S)

HOW INTENSE IS YOUR PAIN? IF '0' IS NO PAIN AND '10' IS SEVERE PAIN? Please circle a number that applies.

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

0	2	4	5	6	8	10
NO HURT	HURTS A LITTLE	HURTS MORE	HURTS ALOT	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORSE

MY SYMPTOMS ARE:

- ☐ CONSTANT AND OCCURS EVERY DAY
- ☐ ARE INTERMITTENT BUT OCCUR EVERY DAY
- ☐ NOT PRESENT EVERY DAY

MY PAIN IS BEST DESCIBED AS:

- ☐ SHARP SHOOTING
- ☐ DULL and ACHY
- ☐ BURNING

MY PAIN DURING THE DAY IS :

- ☐ None or I Ignore it.
- ☐ Slight, but no compromise in my activity. Pain improves with activity.
- ☐ MILD or OCCASIONAL pain. Pain is present more with unusual ACTIVITY, but disappears with rest.
- ☐ MODERATE PAIN, some limitations is usual activity at work or with exercise. Need to take medications regularly
- ☐ MODERATE pain during and after activities. NO pain at Rest (INTERMITTENT). Many limitations.
- ☐ MODERATE pain during and after activities. Many limitations.
- ☐ SEVERE pain, present constantly and intense. Many limitations. Nearly bed-ridden.

WHAT TYPE OF SUPPORT DO YOU NEED WHEN WALKING?

- ☐ None
- ☐ Cane for long walks ONLY
- ☐ Cane at ALL times
- ☐ One Crutch
- ☐ Two Canes
- ☐ Two Crutches Or Walker
- ☐ Unable to walk

DO YOU HAVE (OR HAVE YOU HAD) ANY NUMBNESS IN YOUR FEET?

- ☐ NO
- ☐ YES, CONSTANT
- ☐ YES, BUT NOT CURRENTLY

PLEASE CHECK (X) ANY OF THE *ANTI-INFLAMMATORY* MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTY TAKING.

- ☐ Motrin/Ibuprofen/*Advil*
- ☐ Celebrex
- ☐ Vioxx
- ☐ Valdecoxib/*Bextra*
- ☐ Aspirin
- ☐ Tylenol/Acetaminophen
- ☐ Indomethicin/*Indocin*
- ☐ Naproxen/Naprosyn/*Aleve*
- ☐ Piroxicam/*Feldene*
- ☐ Nabumetone/*Relafen*
- ☐ Tramadol/*Ultram*
- ☐ Etodolac/*Lodine*
- ☐ Diclofenac/*Voltaren*
- ☐ Oxaprozin/*Daypro*
- ☐ Mobic
- ☐ Glucosamine Chondroitin Sulfate
- ☐ Prednisone
- ☐ Other:_____

PLEASE CHECK (X) ANY OF THE *PAIN RELIEVING* AND *MUSCLE RELAXING* MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTY TAKING.

- ☐ Codeine / Tylenol #3
- ☐ Vicodin/Hydrocodone
- ☐ Lortab
- ☐ Darvocet
- ☐ Tylox
- ☐ Percocet
- ☐ Percodan
- ☐ Fioricet
- ☐ Methadone
- ☐ Dilaudid
- ☐ Demerol
- ☐ Roxicet
- ☐ Soma
- ☐ Flexaril
- ☐ Valium
- ☐ Skelaxin
- ☐ Robaxin
- ☐ Zanaflex
- ☐ Other:_____

PLEASE CHECK (X) ANY OF THE FOLLOWING SIDE EFFECTS YOU MAY HAVE EXPERIENCED WHILE TAKING THE ABOVE MEDICATIONS

- ☐ NONE
- ☐ NAUSEA
- ☐ HEARTBURN or UPSET STOMACH
- ☐ ULCERS
- ☐ STOOLS CHANGE COLOR (DARK)
- ☐ DIARRHEA
- ☐ VOMITING
- ☐ OTHER:_____

DURING THE PAST 4 WEEKS HOW OFTEN HAVE YOU TAKEN MEDICATION FOR EACH JOINT?

	RIGHT FOOT/ANKLE	LEFT FOOT/ANKLE
ALWAYS (max dosage)	**1**	**1**
OFTEN (every day, but NOT maximum dosage)	**2**	**2**
SOMETIMES (3-5 times per week)	**3**	**3**
OCCASIONALLY(1-2 times per week)	**4**	**4**
NEVER	**5**	**5**

ARE THE MEDICATIONS THAT YOU ARE TAKING FOR YOUR PAIN RELIEVING YOUR SYMPTOMS?

☐ **YES** ☐ **NO**

HAVE YOU EVER BEEN TREATED AT A *PAIN CLINIC*?

☐ **YES** ☐ **NO**

PREVIOUS TREAMENT FOR YOUR RIGHT FOOT or ANKLE PAIN. PLEASE CHECK (X) those that apply.

TREATMENT	**RIGHT** FOOT/ANKLE….. with relief					
CORTISONE injection	☐YES	☐NO	☐YES	☐NO	Last injection Date:_____	How many Treatments? _____
PHYSICAL THERAPY	☐YES	☐NO	☐YES	☐NO		How many Treatments? _____
ACCUPUNCTURE	☐YES	☐NO	☐YES	☐NO		
CHIROPRACTIC CARE	☐YES	☐NO	☐YES	☐NO		
CAST OR SPLINTED	☐YES	☐NO	☐YES	☐NO		

PREVIOUS TREAMENT FOR YOUR LEFT FOOT or ANKLE. PLEASE CHECK (X) those that apply.

TREATMENT	**LEFT** FOOT/ANKLE….. with relief					
CORTISONE injection	☐YES	☐NO	☐YES	☐NO	Last injection Date:_____	How many Treatments? _____
PHYSICAL THERAPY	☐YES	☐NO	☐YES	☐NO		How many Treatments? _____
ACCUPUNCTURE	☐YES	☐NO	☐YES	☐NO		
CHIROPRACTIC CARE	☐YES	☐NO	☐YES	☐NO		
CAST OR SPLINTED	☐YES	☐NO	☐YES	☐NO		

PREVIOUS SURGERY TO THE ANKLE(S) and/or FOOT/FEET

DATE OF SURGERY	WHICH SIDE?	SURGEON/Hospital	PROCEDURE	COMPLICATIONS
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			

Instructions

Please answer the following questions for the foot/ankle being treated or followed up. If it is BOTH feet/ankles, please answer the questions for your **worse** side. All questions are about how you have felt,
on average, during the **past week**. If you are being treated for an injury that happened less than one week ago, please answer for the period since your injury.

1. During the **past week**, how **stiff** was your foot/ankle? (Circle one response.)

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

2. During the **past week**, how **swollen** was your foot/ankle? (Circle one response.)

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

During the **past week**, please tell us about how painful your foot/ankle was during the following activities. (Circle ONE response on each line that best describes your average ability.)

	Not Painful	Mildly Painful	Moderately Painful	Very Painful	Extremely Painful	Could not do because of foot/ankle pain	Could not do for other reasons
3. Walking on **uneven** surfaces?	1	2	3	4	5	6	7
4. Walking on **flat** surfaces?	1	2	3	4	5	6	7
5. Going up or down stairs?	1	2	3	4	5	6	7
6. Lying in bed at night?	1	2	3	4	5	6	7

During the **past week**, did your foot/ankle **give way** during the following activities? (Circle ONE response on each line that best describes you for each activity level.)

	Did not give way at all	Partially gave way, but I did not fall	Completely gave way, so that I fell	Could not do the activity because of foot/ankle giving way	Could not do for other reasons
7. Strenuous activity, such as heavy physical work, skiing, tennis?	1	2	3	4	5
8. Moderate activity, such as moderate physical work, jogging, running?	1	2	3	4	5
9. Light activity, such as walking, housework, yard work?	1	2	3	4	5

10. Which of the following statements **best** describes your ability to get around most of the time during the **past week**? (Circle one response.)

1 I did not need support or assistance at all.
2 I mostly walked without support or assistance.
3 I mostly used one cane or crutch to help me get around
4 I mostly used two canes, two crutches or a walker to help me get around.
5 I used a wheelchair.
6 I mostly used other supports or someone else had to help me get around.
7 I was unable to get around at all.

11. How much trouble did you have with balance during the **past week**? (Circle one response.)

1 No trouble at all
2 A little bit of trouble
3 A moderate amount of trouble
4 Quite a bit of trouble
5 A great amount of trouble
6 I cannot balance on my feet at all

12. How difficult was it for you to put on or take off socks/stockings during the **past week**? (Circle one response.)

1 Not at all difficult **2** A little bit difficult **3** Moderately difficult **4** Very difficult **5** Extremely difficult **6** Can not do it at all

All questions are about how you have felt on average **during the past week**.
During the **past week**, please tell us about how **painful** your **foot or ankle** was when you were performing the
following activities. (Circle ONE response on each line that best describes your average ability.)

	No Pain	Mild Pain	Moderate Pain	Severe Pain	Extremely Painful	Could not do because of foot/ankle pain	Could not do for other reasons
13. Strenuous activity, such as heavy physical work, skiing, tennis	**1**	**2**	**3**	**4**	**5**	**6**	**7**
14. Moderate activity, such as moderate physical work, jogging, running	**1**	**2**	**3**	**4**	**5**	**6**	**7**
15. Light activity, such as walking, house work, yard work	**1**	**2**	**3**	**4**	**5**	**6**	**7**
16. Standing for an hour	**1**	**2**	**3**	**4**	**5**	**6**	**7**
17. Standing for minutes	**1**	**2**	**3**	**4**	**5**	**6**	**7**

18. How much difficulty do you have walking on uneven surfaces (eg., small stones, rocks, sloping ground)? (Circle one response.)

1 No difficulty
2 Mild difficulty
3 Moderate difficulty
4 Severe difficulty
5 Extreme difficulty
6 Cannot do because of foot/ankle
7 Cannot do for other reasons

What types of shoes can you wear comfortably? (Circle one response on each line.)

	YES	NO	NOT APPLICABLE
19. Any women's shoe (including high heels) OR any men's shoe (including fancy dress shoes)	**1**	**2**	**3**
20. Most women's dress shoes (except high heels) OR most means dress shoes	**1**	**2**	**3**
21. Sneakers, walking, or casual shoes	**1**	**2**	**3**
22. Orthopaedic or prescription shoes	**1**	**2**	**3**
23. All shoes	**1**	**2**	**3**

24. How much did your foot or ankle problem interfere with your normal work, including work both outside the home and house work? (Circle one response.)

1 Not at all **2** A little bit **3** Moderately **4** Quite a bit **5** Extremely **6** Unable to work due to foot and ankle problems

25. How much did your foot or ankle problem interfere with your life and your ability to do what you want? (Circle one response.)

1 Not at all **2** A little bit **3** Moderately **4** Quite a bit **5** Extremely **6** the pain/symptoms ruin everything

Which ONE of the following includes the highest level of formal schooling that you have had?

- ☐ No Formal Schooling
- ☐ Elementary School
- ☐ High School
- ☐ Some College
- ☐ College Degree
- ☐ Graduate School

Are You married?

- ☐ Yes, married
- ☐ No, Never married
- ☐ No, divorced or separated
- ☐ No, widowed

Which ONE of the following best describes your living current living arrangement?

- ☐ I live alone in a house or apartment
- ☐ I live with my family in a house or apartment
- ☐ Assisted Living Center: *Location* _____
- ☐ Nursing Home: *Location* _____
- ☐ other (please Describe) _____

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

- Much better than one year ago ☐
- Somewhat better now than one year ago ☐
- About the same as one year ago ☐
- Somewhat worse now than one year ago ☐
- Much worse now than one year ago ☐

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**

	Activities	**Yes, Limited A Lot**	**Yes, Limited A Little**	**Not Limited At All**
3(a)	**Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b)	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c)	Lifting or carrying groceries	1	2	3
3(d)	Climbing **several** flights of stairs	1	2	3
3(e)	Climbing **one** flight of stairs	1	2	3
3(f)	Bending, kneeling, or stooping	1	2	3
3(g)	Waling **more than a mile**	1	2	3
3(h)	Walking **several blocks**	1	2	3
3(i)	Walking **one block**	1	2	3
3(j)	Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	(Please circle one number on each line.)	**Yes**	**No**
4(a)	Cut down on the **amount of time** you spent on work or other activities	1	2
4(b)	Accomplished less than you would like	1	2
4(c)	Were **limited** in the **kind** of work or other activities	1	2
4(d)	Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)?

	(Please circle one number on each line.)	**Yes**	**No**
5(a)	Cut down on the **amount of time** you spent on work or other activities	1	2
5(b)	Accomplished less than you would like	1	2
5(c)	Didn't do work or other activities as **carefully** as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

- None ☐
- Very mild ☐
- Mild ☐
- Moderate ☐
- Severe ☐
- Very Severe ☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

	(Please circle one number on each line.)	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
9(a)	Did you feel full of life?	1	2	3	4	5	6
9(b)	Have you been a very nervous person?	1	2	3	4	5	6
9(c)	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d)	Have you felt calm and peaceful?	1	2	3	4	5	6
9(e)	Did you have a lot of energy?	1	2	3	4	5	6
9(f)	Have you felt downhearted and blue?	1	2	3	4	5	6
9(g)	Did you feel worn out?	1	2	3	4	5	6
9(h)	Have you been a happy person?	1	2	3	4	5	6
9(i)	Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

11. How TRUE or FALSE is each of the following statements for you?

	(Please circle one number on each line.)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
11(a)	I seem to get sick a little easier than other people	1	2	3	4	5
11(b)	I am as healthy as anybody I know	1	2	3	4	5
11(c)	I expect my health to get worse	1	2	3	4	5
11(d)	My health is excellent	1	2	3	4	5

Thank You!

SOCIAL HABITS

DO YOU USE TOBACCO PRODUCTS? **YES NO.**
☐ CHEWING TOBACCO ☐ CIGARS ☐ CIGARETTES ☐ PIPE
If ***yes***, how many packs/cigars a day?_____. About what year did you start?_____.

HAVE YOU EVER USED TOBACCO? **YES NO.**
If ***yes***, how many years?_____. About what year did you quit?_____.

DO YOU DRINK ALCOHOL SOCIALLY? **YES NO.**
If ***yes***, how many drinks per week?_____.
DO YOU FEEL YOU DRINK ALCOHOL IN EXCESS? **YES NO.**

DO YOU USE RECREATIONAL DRUGS? **YES NO.**
HAVE YOU EVER USED RECREATIONAL DRUGS? **YES NO.**

DO YOU HAVE ANY **ALLERGIES** TO MEDICATIONS? **YES NO.**
☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Betadine
☐ OTHER _____

DO YOU HAVE AN **ALLERGY** TO LATEX? **YES NO.**
DO YOU HAVE ANY **ALLERGIES** TO FOOD? **YES NO.**

MEDICAL PROBLEMS (see next page): check all that apply, Now or in the Past

☐ **I HAVE NOT HAD ANY MEDICAL PROBLEMS OR PREVIOUS ILLNESSES**

General	NOW	PAST
Fever		
Chills		
Drenching night sweats		
Itching		
Fatigue		
Change in weight		
Change in appetite		
HIV/AIDS		
Alcoholism		
Fibromyalgia		
Skin		
Jaundice		
Skin cancer (what kind)		
Psoriasis		
Eczema		
Head		
Headache/migraines		
Other head pain		
Trauma		
Skull fracture		
Ears		
Decreased hearing		
Tinnitus or ringing		
Discharge		
Infection		
Pain		
Eyes		
Pain		
Infection		
Glaucoma		
Dry eyes		
Macular degeneration		
blindness		
Nose		
Frequent bleeding		
Sinus Problems		
Changes in smell		
Mouth/Throat		
Tongue problems		
Change in taste		
Mouth lesions or ulcers		
Dentures		
Dry mouth		
Bleeding(mouth/gums)		
Gum disease		
Problems swallowing		
Neck		
Thyroid problems		
Lumps, masses, nodules		
Breasts		
Masses		
Discharge		
Pain		
Cancer		

Respiratory	NOW	PAST
Shortness of breath (SOB)		
Asthma		
COPD/Emphysema		
T.B.		
Positive PPD or prior BCG		
Pneumonia or bronchitis		
Wheezing		
Chronic Cough		
Hemoptysis		
Pulmonary embolus		
Sleep apnea		
Any abnormal chest X-ray in past		
Cardiovascular		
High Blood pressure		
Chest pain or Angina		
Heart attack		
Murmur		
arrhythmia		
Atrial Fibrillation		
Normal Stress Test		
Abnormal Stress Test		
Dizziness		
Syncope or near-syncope		
Loss of consciousness		
Edema or swelling in both feet		
Blood clots		
Abdominal		
Pain		
Nausea/vomiting		
Change in bowel habits		
Diarrhea or constipation		
Bright red blood per rectum		
History of polyps		
Colon cancer		
Pancreatitis		
Gall bladder disease		
Gallstones		
Irritable bowel syndrome (IBS)		
Inflammatory bowel disease (IBD)		
Hepatitis		
Hernias		
GU		
Frequency		
Burning		
Blood in the urine		
Kidney stones		
Urinary tract infection (UTI)		
Cystitis		
Incontinence		
Bladder cancer		
Prostate cancer		
Uterus/cervical cancer		

GU (men)	NOW	PAST
Testicular pain or masses		
GU (women)		
Irregular menses/amenorrhea		
Dysmenorrhea		
Hot flashes		
Pregnancy loss		
Extremities-muscles-joints		
Osteoarthritis		
Rheumatoid Arthritis		
Gout		
Morning stiffness		
Joint injuries		
Raynaud's		
Morning stiffness		
Back pain		
Neck pain		
Neurologic		
Seizures or epilepsy		
Stroke		
Dizziness or vertigo		
Tremor		
Involuntary movements		
Balance problems		
Numbness or tingling in Feet		
Numbness or tingling in Hands		
Memory concerns		
Endocrine		
Thyroid problems		
Heat or cold intolerance		
Diabetes Type I (Insulin Requiring		
Diabetes Type II (oral medications)		
Diabetes-borderline		
Excessive thirst		
Frequent Fractures		
Loss of height		
Hematologic		
Anemia		
Sickle Cell Disease		
Swollen lymph nodes		
Blood diseases		
Leukemia/lymphoma		
Bleeding problems		
Blood clots		
Past use of blood thinners		
Psychiatric		
Depressive symptoms (e.g. feeling down)		
Anxious		
Phobias		
OCD behaviors		
ADD/ADHD behaviors		
Panic attacks		
Hallucinations (visual/auditory)		
Suicidal/homicidal thoughts		
Bipolar Disorder		

MEDICATIONS: Please list all medications you are taking including over-the-counter medications.

☐ **I DO NOT TAKE ANY MEDICATION**

MEDICATION	DOSEAGE	HOW OFTEN	MEDICATION	DOSEAGE	HOW OFTEN
1.			**5.**		
2.			**6.**		
3.			**7.**		
4.			**8.**		

PERSONAL SURGICAL HISTORY

☐ **I HAVE NEVER HAD SURGERY**

PLEASE CHECK ALL THAT APPLY AND GIVE APPROXIMATE **YEAR** SURGERY WAS PERFORMED.

ABDOMINAL SURGERY:

☐ APPENDIX	☐ GASTRIC BYPASS	☐ ORGAN TRANSPLANT
☐ GALL BLADDER REMOVAL	☐ COLON RESECTION or COLOSTOMY	
☐ HERNIA REPAIR	☐ NISSEN (reflux surgery)	
☐ AORTIC ANEURYSM (AAA)	☐ REMOVAL OF SPLEEN	

CARDIOVASCULAR SURGERY:

☐ ANGIOPLASTY or STENT	☐ OPEN HEART SURGERY and BYPASS	☐ OPEN HEART SURGERY and VALVE SURGERY
☐ ARTERY BYPASS IN LEGS	☐ VEIN STRIPPING	☐ CAROTID (neck) ARTERY SURGERY

MUSCULOSKELETAL:

☐ CARPAL TUNNEL SURGERY	☐ FRACTURE REPAIR	☐ JOINT RELACEMENT SURGERY
☐ ARTHROSCOPY SURGERY	☐ CERVICAL/NECK SPINE SURGERY	☐ LUMBAR/LOWER BACK SURGERY

OTHER:

☐ THYROID REMOVAL	☐ CATARACT SURGERY	☐ BRAIN SURGERY	☐ LASIX EYE SURGERY
☐ TONSILLECTOMY	☐ PLASTIC SURGERY	☐ SINUS SURGERY	

FEMALES ONLY:

☐ HYSTERECTOMY (uterus)	☐ TUBAL LIGATION	☐ C-SECTION
☐ OOPHORECTOMY (ovaries)	☐ BLADDER SUSPENSION SURGERY	☐ BREAST BIOSPY or MASTECTOMY

MALES ONLY:

☐ PROSTATE SURGERY	☐ VASECTOMY	☐ TESTICULAR SURGERY
☐ BREAST BIOSPY or MASTECTOMY		

OTHER SURGERY NOT LISTED ABOVE:

_____

_____

FAMILY HISTORY : DOES YOUR GRANDPARENTS, MOTHER, FATHER OR BROTHERS/ SISTERS OR CHILDREN HAVE ANY ON THE FOLLOWING MEDICAL PROBLEMS (LIVING OR DECEASED)?

Disease or Problem	yes	no	Relation		Disease or Problem	yes	no	Relation
CANCER					**HEART DISEASE**			
ANESTHESIA PROBLEMS					**BLEEDING PROBLEMS**			
TUBERCULOSIS					**CLOTTING PROBLEMS**			
Kidney problems					**JOINT REPLACEMENT**			

SIGN HERE

Signature of person filling out this form

OFFICE USE ONLY:

	RIGHT F/A	LEFT F/A
Active/Passive DORSIFLEX	/	/
Act./Passive PLANTARFLEX	/	/
Act./Passive pronation	/	/
Act./Passive supination	/	/

- Demographics
- Location of symptoms
- Mechanism of injury
- Date of Injury
- Quality of symptoms
- Onset and resolution of symptoms.
- Frequency of episodes.
- Limitations in activity
- Severity of symptoms (pain scale)
- Sports participation
- Alleviating factors
- Exacerbating factors
- Associated symptoms (numbness, tingling,LBP, locking,catching,instability)
- Assistive devices
- Previous treatment
- Previous workup (MRI, bone scan, etc)

Doctor/PA's signature