THE Portland Clinic
We specialize in you.

Foot & Ankle Questionnaire

PATIENT LABEL

Referring Provider:_____ Your Preferred Name:_____
Primary Care Physician:_____ Preferred Pharmacy:_____

Why are you here for evaluation today?

_____
_____
_____

How do you rate your pain? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

How long have you had this problem?
_____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Have you experienced this problem in the past?
☐ Yes ☐ No

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

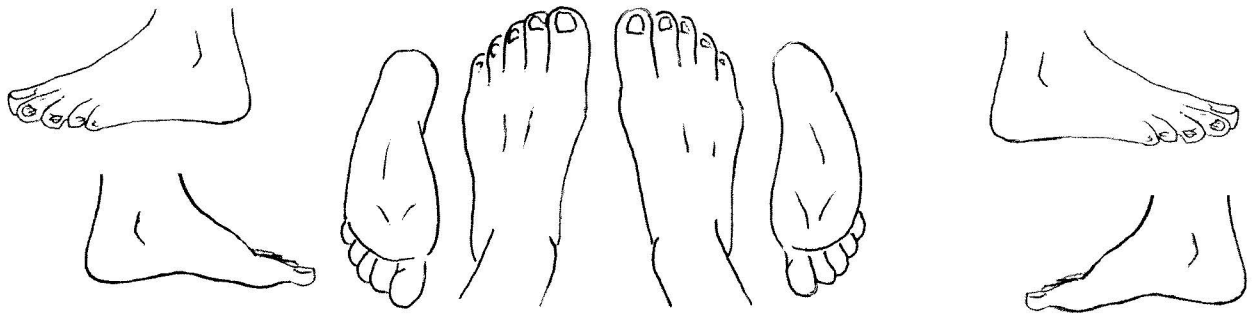
What treatments have you tried?
☐ Rest ☐ Ice ☐ Medication: _____ ☐ Bracing/Wraps ☐ Arch Supports ☐ Physical Therapy
☐ Other: _____

Have you seen another foot/ankle doctor for this problem?
☐ Yes ☐ No

Do you have any history of foot/ankle surgery?
☐ No ☐ Yes: _____

Do you have any history of foot/ankle injury?
☐ No ☐ Yes: _____

Please mark the site of your pain/problem with an "X":



LEFT RIGHT

Review of Systems: Please indicate anything that applies to you TODAY.

- ☐ Constitutional: fever, chills, fatigue, unexpected weight gain or loss
- ☐ CV: chest pain, abnormal heart rhythm
- ☐ Respiratory: difficulty breathing, shortness of breath, sleep apnea, cough
- ☐ GI: heartburn, ulcers, nausea, diarrhea, vomiting
- ☐ MS: joint pain, muscle pain, bone pain
- ☐ Skin: rash, itching, skin color changes
- ☐ Endocrine: diagnosis of diabetes
- ☐ Hematologic: easy bruising, easy bleeding
- ☐ Neurologic: headache, numbness, tingling, dizziness, seizures, vertigo
- ☐ Psychiatric: depression, anxiety

Social History:

Do you smoke?

- ☐ Current Smoker: _____ packs per day
- ☐ Former smoker: Quit date: _____
- ☐ Never smoker

Do you drink alcohol? ☐ No ☐ Yes, number drinks per week: _____

Continue to complete this section ONLY if:

1) Your primary care physician is outside The Portland Clinic, or 2) You do not have a primary care physician

Medical History:

Please list past and current medical history:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list previous surgeries (provide procedure and approximate date):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any prescription medications you are currently taking, including dosage and frequency:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any allergies to medications and the reaction that you experienced:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family History: Please check any of the following severe illnesses that may run in your family and circle the family member involved. (**M**=mother, **F**=father, **S**=sibling, **MGM**=Maternal grandmother, **MGF**=Maternal grandfather, **PGM**=Paternal grandmother, **PGF**=Paternal grandfather)

- ☐ Arthritis: M F S MGM MGF PGM PGF
- ☐ Cancer: M F S MGM MGF PGM PGF
- ☐ Diabetes : M F S MGM MGF PGM PGF
- ☐ Heart Disease: M F S MGM MGF PGM PGF
- ☐ High Cholesterol: M F S MGM MGF PGM PGF
- ☐ Hypertension: M F S MGM MGF PGM PGF
- ☐ Kidney Disease: M F S MGM MGF PGM PGF