Foot & Ankle Clinic of Spokane

Last Name: Legal First Name: MI: _____

DOB: Age: _____ Gender: Male Female Weight:
Height: _____ Shoe Size: _____

PCP or Referring Physician: Phone: Date Last Seen:

Reason for Visit with Us: Date Occurred:

Is Your Condition: **None** Work Related Due to an Automobile Accident Due to a liability claim

Current Problem

Location: π Bottom of In between Inside of foot Left π Right Top of Other:

Site: Ankle Arch Ball of foot Calf Foot Heel Leg Toe(s) Other:

Started: Today #_____Days #_____Weeks #_____Months #_____Years

How often: At night Constant In AM Off and on Rare Recurrent Other:

Feels like: Aching Bruised Burning Cramping Deep Dull Improving Inflamed Itchy Numb Pressure Sharp Swollen Tender Tight Tingling Other:

Pain scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 –worst
Improving Resolved Unbearable Unchanged

Caused by: Barefoot Fell Increased activity Injury Running Unknown Other:

Better with: Compression Elevation Heat Ice In shoes Medication Rest Other:

Worse with: Increased activity In shoes No shoes Pressure Running Walking Other:

Also have: Back pain Dementia Diabetes Fatigue Numbness Osteoporosis Over weight Swell

πHeadaches Infection Muscle spasm πWear orthotics Weakness Other:

Current Conditions—mark NONE if the condition below does NOT apply to you

Symptoms: **None** Chills ExcessiveWeightGain/Loss Fatigue Fever Loss of appetite Night sweats

Eyes: **None** Double vision Dry eyes Loss of vision Pain Redness Other:

Ears, Nose, Throat: **None** Ear pain Ear ringing Dizziness Hearing loss Hoarseness Loss of smell

Heart: **None** Chest pain Rapid heart rate Shortness of breath Swelling in legs or feet

Respiratory: **None** πProductive cough Shortness of breath Snoring Sleep apnea Wheezing Other:

Intestinal: **None** Abdominal Pain Bloating/Gas Constipation Diarrhea Nausea Vomiting

Urinary, Reproductive: **None** Blood Urine Pregnant Urinary incontinence Sexually transmitted disease

Musculoskeletal: **None** Artificial joints Soft tissue pain Weakness Other:

Skin: **None** Ingrown nail Lesion Non-healing wound Rash Ulcer Wart Other:

Neurological: **None** Memory loss Migraines Numbness Paralysis Seizures Strokes

Psychiatric: **None** Anxiety Claustrophobia Depression Hallucinations Restlessness

Endocrine: **None** Cold intolerance Diabetes Excessive thirst Excessive urination Heat intolerance

Hematological: **None** Anemia Blood transfusions Easy bruising Prolonged bleeding Other:

Immunologic: **None** Allergies HIV Recurrent Infections Other:

Pharmacy and Current Medications:

Pharmacy:	**Location:**		**Zip:**	**Phone:**
Medication	Dosage	How Often	Medication	Dosage How Often

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date