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New Patient Medical History for ANKLE Symptoms

Name: _____ Today's Date: _____

Age: _____ Phone number: _____

Referred by: _____ Date of Injury/Onset of symptoms: _____

Reason for visit. Describe injury or onset in detail: LEFT RIGHT _____

Pain: Sharp Dull Stabbing Burning Other: _____

Constant Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10

Location: _____

Does the pain go anywhere else (describe)? _____

What makes pain worse? Standing Walking Running Stairs Squatting

Pivoting Other: _____

What makes pain better? Rest Activity Modification Ice/Heat Meds

Other: _____

What other symptoms are present? Catching Popping Grinding Locking Frequent sprains

Multiple Sprains in Past Swelling (constant fluctuates)

What treatments have you attempted and what effect? (PT, meds, injections, brace) _____

Can you work or participate in sports with current symptom? NO YES

Do you have light duty available at work? NO YES

Past Medical and Family History (check all that apply You Family History)

High Blood Pressure Heart Disease Stroke Diabetes

COPD Asthma Reflux Ulcers

Kidney Disease Vascular Disease Hepatitis Blood Clots

Bleeding Disorder Cancer Arthritis Seizures

Headaches HIV

Other: _____

Past Surgical History (check all that apply)

Appendectomy Gall Bladder Hernia Breast

Heart Bypass Heart Valve Pacemaker Spine/Neck

Arthroscopy Joint Replacement Rotator Cuff Hysterectomy

Other: _____

Drug Allergies (list all known drug allergies)

Please complete both sides of form, sign and date.

Medications: (please list all prescription and over the counter medications and supplements)

Separate List Attached

Social History

Single Married Divorced Widowed Children? NO YES # _____

Do you smoke? NO YES _____ packs per day

Do you drink alcohol? NO YES Do you use drugs? NO YES (list) _____

What is your occupation? _____

Do you exercise regularly? NO Yes _____ days per week

Do you participate in sports? NO YES (list) _____

Review of Systems

Do you currently or frequently have: (check all that apply)

Constitutional

- Weight loss
- Weight gain
- Fever
- Chills

Eyes

- Blurred vision
- Double vision

Ears, Nose, Throat

- Hearing loss
- Ringing in ears
- Congestion
- Sore throat

Respiratory

- Shortness of breath
- Wheezing
- Cough
- Coughing blood

Cardiovascular

- Chest pain
- Palpitations

Genitourinary

- Painful urination
- Blood in urine
- Urgency/frequency
- Incontinence

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Incontinence

Skin

- Rash
- Skin lesion
- Nail problems

Neurological

- Headaches
- Seizures
- Dizziness
- Balance problems
- Numbness/tingling
- Weakness

Endocrine

- Thirst
- Tired/sluggish
- Hot
- Cold

Hematologic

- Bleeding problems
- Bruising
- Limb swelling

Psychiatric

- Depression
- Anxiety
- Insomnia
- Addiction
- Drug use

Musculoskeletal (other than current complaint)

Joint pain (list) _____

- Back pain
- Neck pain
- Joint stiffness
- Joint swelling
- Gout

Other Medical

Concerns: (list)

Height: _____

Weight: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

