

**ORTHOPAEDIC SURGERY**  
PRACTICE LIMITED  
TO THE  
FOOT AND ANKLE  
CHILDREN & ADULTS



RONALD SMITH, M.D.

**We are pleased that you have returned to our office for your orthopaedic foot and ankle care.**

**Please fill out the interval visit forms. Describe your new problem or current symptoms of a persistent problem. If you have a persistent problem that was previously treated in this office, note the treatment or evaluation you have received since your last visit here.**

**If your last visit was over 6 months ago, you will be given a copy of your previous general medical history. Add or remove information as appropriate, using the red pen. Please date the copy.**

**The forms are detailed but allow us to have information that helps to provide comprehensive medical or surgical care for your foot and ankle.**

**Thank you for your assistance. We look forward to seeing you again.**

**Sincerely,**

**Ronald W. Smith, M.D.**

## FOOT AND ANKLE HISTORY

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

I have brought in x-rays or other images today: Yes  No

Source of x-rays/images (office or hospital name) \_\_\_\_\_

Occupation \_\_\_\_\_ Duration \_\_\_\_\_

REFERRING PARTY: (Please give name)

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Friend \_\_\_\_\_ Family Member \_\_\_\_\_

Insurance Company \_\_\_\_\_ Attorney \_\_\_\_\_

Other \_\_\_\_\_

PERSONAL PHYSICIAN (Same as referring physician )

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ E-Mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of last visit \_\_\_\_\_

PRESENT GOAL IN SEEKING EVALUATION: Check one or more.

Relief of pain  Correction of deformity  Improvement of appearance

Second opinion  Other \_\_\_\_\_

MAIN PROBLEM: Check one or more.

Pain or aching  Swelling  Weakness  Stiffness  Deformity  Lump

Instability or giving out  Other \_\_\_\_\_

LOCATION & DURATION OF MAIN PROBLEM: Check one or more. (indicate # of weeks, months, years)

Problem:	Duration Of Symptoms			Or Date Of Onset	Indicate <b>Most Severe</b> *		
Leg	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Leg
Ankle	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Ankle
Heel	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Heel
Bunion	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Bunion
Top of arch	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Top of arch
Sole of arch	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Sole of arch
Side of the foot	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Side of the foot
Ball of foot	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Ball of foot
Great toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> Great toe
2nd toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> 2nd toe
3rd toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> 3rd toe
4th toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> 4th toe
5th toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# ___ weeks	# ___ months	# ___ years	_____	<input type="checkbox"/> 5th toe

\* If multiple problems, indicate the most severe in the right column.

DESCRIPTION OF ONSET: Check one or more.

Congenital--  Crush-  Repetitive use--  Sudden onset ---  Work-related ----

Fall -----  Twist--  Direct blow -----  Gradual onset ---  Sports-related ---

No Injury ----  Other \_\_\_\_\_

BRIEFLY DRAW LOCATION OF MAIN PROBLEMS ON THE DIAGRAM ON THE NEXT PAGE.

Patient's Name \_\_\_\_\_ Chart No. \_\_\_\_\_

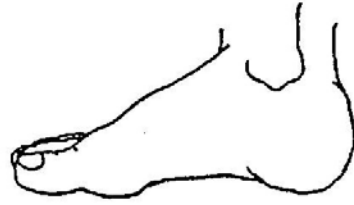
Date \_\_\_\_\_

CIRCLE AREA OF SYMPTOMS (label pain, swelling, weakness, stiffness, numbness, lumps, etc.)

RIGHT



Lateral  
(Outside)

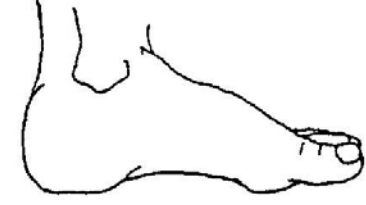


Medial  
(Inside)

LEFT



Lateral  
(Outside)



Medial  
(Inside)



Dorsal  
(Top)

RIGHT



Plantar  
(Bottom)

LEFT



Dorsal  
(Top)



Plantar  
(Bottom)

Briefly describe what happened when symptoms started, **and specify your location** at onset (home, work, etc.)

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PREVIOUS TREATMENT OR EVALUATIONS: NONE  (If none, skip to SELF CARE)

The **FIRST** doctor/E.R./Urgent Care I saw for this problem:

Name \_\_\_\_\_ City \_\_\_\_\_

This doctor is a: Emergency Room Doctor  Podiatrist  Company doctor

Family doctor  Orthopedic surgeon  Other \_\_\_\_\_

**Date of first exam** \_\_\_\_\_ **Date of last visit** \_\_\_\_\_ **# of visits** \_\_\_\_\_

Tests: X-Rays  Blood Tests  Nerve Tests  CT scan  Bone Scan  MRI

TREATMENT:

Steroid injections -----  How many \_\_\_\_\_ Date of last one \_\_\_\_\_ Helped? Yes  No

Anti-inflammatory pills --  Drug names \_\_\_\_\_ Helped? Yes  No

Pain pills -----  Drug names \_\_\_\_\_ Helped? Yes  No

Physical therapy -----  Number of visits \_\_\_\_\_ Helped? Yes  No

Pads/shoe modification  Type \_\_\_\_\_ Helped? Yes  No

Orthotics -----  Type \_\_\_\_\_ Helped? Yes  No

Cast  or Walker Boot  How long? \_\_\_\_\_ Helped? Yes  No

Surgery performed -----  Recommended surgery, did not do  Helped? Yes  No

Other \_\_\_\_\_ Helped? Yes  No

The **SECOND** doctor I saw for this problem:

Name \_\_\_\_\_ City \_\_\_\_\_

This doctor is a: Emergency Room Doctor  Podiatrist  Company doctor

Family doctor  Orthopedic surgeon  Other \_\_\_\_\_

**Date of first exam** \_\_\_\_\_ **Date of last visit** \_\_\_\_\_ **# of visits** \_\_\_\_\_

Tests: X-Rays  Blood Tests  Nerve Tests  CT scan  Bone Scan  MRI

TREATMENT:

Steroid injections -----  How many \_\_\_\_\_ Date of last one \_\_\_\_\_ Helped? Yes  No

Anti-inflammatory pills --  Drug names \_\_\_\_\_ Helped? Yes  No

Pain pills -----  Drug names \_\_\_\_\_ Helped? Yes  No

Physical therapy -----  Number of visits \_\_\_\_\_ Helped? Yes  No

Pads/shoe modification  Type \_\_\_\_\_ Helped? Yes  No

Orthotics -----  Type \_\_\_\_\_ Helped? Yes  No

Cast  or Walker Boot  How long? \_\_\_\_\_ Helped? Yes  No

Surgery performed -----  Recommended surgery, did not do  Helped? Yes  No

Other \_\_\_\_\_ Helped? Yes  No

IF YOU SAW MORE THAN TWO DOCTORS FOR THIS PROBLEM PLEASE ASK THE FRONT DESK STAFF FOR AN ADDITIONAL PAGE.