

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



A Medical Group, Inc

RONALD SMITH, M.D.

**Dear Patient,**

**We are pleased that you have selected our office for your orthopaedic foot and ankle care. A brochure that tells about our office and staff is enclosed.**

**Please fill out the enclosed forms completely, marking the “NONE” boxes where appropriate and listing where indicated the approximate dates of previous foot and ankle services, treatments, and evaluations.**

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

**Please bring with you, or arrange to send in advance by first class mail, all X-RAYS, CT AND BONE SCAN STUDIES, AND MRI FILMS AND REPORTS that you have had done in regard to your foot or ankle problem.**

**Thank you for your assistance. We look forward to meeting you.**

**Sincerely,**

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



**RONALD W. SMITH, M.D.**

2651 ELM AVENUE, SUITE 205  
LONG BEACH, CALIFORNIA 90806  
(562) 424-9444 • Fax (562) 988-0309  
E-MAIL: rsmith@memnet.org  
www.BalanceOrthoFoot.com

**PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)**

**PATIENT**

PATIENT NUMBER		DOCTOR			TODAY'S DATE	
PATIENT'S LEGAL NAME			DATE OF BIRTH	AGE	SOCIAL SECURITY #	CELL NO.
NAME PREFERENCE			DRIVER'S LICENSE #		SEX	MARITAL STATUS
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY			CITY AND STATE		ZIP CODE	AREA CODE
PATIENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)		AREA CODE	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS			CITY AND STATE			ZIP CODE
IN CASE OF EMERGENCY CONTACT:				PHONE #	RELATIONSHIP	
SPOUSE'S NAME		DATE OF BIRTH	SOCIAL SECURITY NO.		DRIVER'S LICENSE #	
SPOUSE'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)			BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE	
WHO REFERRED YOU TO THIS OFFICE?						
HAVE WE EVER TREATED ANY MEMBERS OF YOUR FAMILY? (Y/N)				NAME OF YOUR FAMILY DOCTOR:		

**IF THE PATIENT IS A MINOR OR STUDENT**

MOTHER'S NAME		STREET ADDRESS / CITY / STATE / ZIP			HOME PHONE #
MOTHER'S EMPLOYER		BUSINESS PHONE NO.		SOCIAL SECURITY NO.	
EMPLOYER'S STREET ADDRESS		CITY / STATE /			ZIP
FATHER'S NAME		STREET ADDRESS / CITY / STATE / ZIP			HOME PHONE #
FATHER'S EMPLOYER		BUSINESS PHONE #		SOCIAL SECURITY NO.	
EMPLOYER'S STREET ADDRESS		CITY / STATE / ZIP			

**INSURANCE INFORMATION**

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		STREET ADDRESS		CITY / STATE / ZIP		HOME PHONE #
INSURANCE NAME & ADDRESS		NAME OF POLICY HOLDER		CERTIFICATE #		GROUP #
INSURANCE NAME & ADDRESS		NAME OF POLICY HOLDER		CERTIFICATE #		GROUP #
MEDICARE		MEDICARE #				
MEDICAID		PROGRAM #			COUNTY #	

**INJURY**

DESCRIBE INJURY AND HOW IT HAPPENED		
<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER (Explain)		
		DATE OF INJURY
		APPROXIMATE TIME OF INJURY

## **PROVIDER'S FINANCIAL POLICY**

Please note that payment in full is required at the time of service. For your convenience, we accept personal checks, Visa, Master Charge or American Express, as well as cash. Any insurance coverage that you may have is intended to protect you against financial loss and not as payment in full for your care. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by (the patient) (or provider?) in writing. A photocopy of this document is to be considered as valid as the original.

## **PATIENT'S INSURANCE AUTHORIZATION**

I hereby authorize the processing of the listed medical insurance, either electronically or manually, by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to be paid to the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

## **PATIENT'S TREATMENT AUTHORIZATION**

I authorize treatment by the Balance Orthopaedic Foot and Ankle Center. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all the charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

\_\_\_\_\_  
Patient's Name (Please Print)                      Signature of Patient/Guardian                      Date

## **TREATMENT OF MINOR**

I authorize Balance Orthopaedic Foot and Ankle Center to treat the minor named below.

\_\_\_\_\_  
Minor's Name    Signature of Parent/Guardian    Date

# BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_ Age \_\_\_\_ Todays 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. \_\_\_\_\_

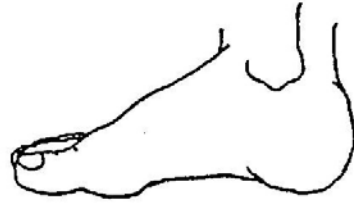
Date \_\_\_\_\_

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

RIGHT



Lateral  
(Outside)



Medial  
(Inside)

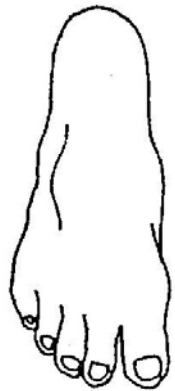
LEFT



Lateral  
(Outside)



Medial  
(Inside)



Dorsal  
(Top)

RIGHT



Plantar  
(Bottom)

LEFT



Dorsal  
(Top)



Plantar  
(Bottom)

**BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY**

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 CHECK  AND CONTINUE ON THE BACK SIDE OF THIS PAGE.

## BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

The **THIRD** 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 -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot <input type="checkbox"/>		How long? _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **FOURTH** 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 -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot <input type="checkbox"/>		How long? _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **FIFTH** 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 -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot <input type="checkbox"/>		How long? _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

FOOT AND ANKLE SURGERY: list earliest surgery first NONE   
(Include foot surgeries not related to present problem)

- 1. Date \_\_\_\_\_ Doctor \_\_\_\_\_ Hospital \_\_\_\_\_
Type of surgery \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_
Helped? Yes  No  Complications? (list) \_\_\_\_\_
Other \_\_\_\_\_
2. Date \_\_\_\_\_ Doctor \_\_\_\_\_ Hospital \_\_\_\_\_
Type of surgery \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_
Helped? Yes  No  Complications? (list) \_\_\_\_\_
Other \_\_\_\_\_
3. Date \_\_\_\_\_ Doctor \_\_\_\_\_ Hospital \_\_\_\_\_
Type of surgery \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_
Helped? Yes  No  Complications? (list) \_\_\_\_\_
Other \_\_\_\_\_

SELF CARE: None  Other \_\_\_\_\_
Changed shoes  Trimmed calluses  Store bought pads or arch supports

ANTICIPATED SURGERY:
Would consider surgery if the doctor thinks it's necessary? Yes  No

FACTORS OF PAIN OR DISCOMFORT: check one or more.
Walking in shoes \_\_\_\_\_ Being on my feet all day \_\_\_\_\_
Walking barefooted \_\_\_\_\_ Cold, damp weather \_\_\_\_\_
First getting up in the morning \_\_\_\_\_ Walking while carrying loads \_\_\_\_\_
Walking after resting or sitting \_\_\_\_\_ Climbing stairs or ladders \_\_\_\_\_
At rest or at night \_\_\_\_\_ Squatting \_\_\_\_\_
Other \_\_\_\_\_

FACTORS OF RELIEF: check one or more.
Staying off my feet \_\_\_\_\_ Removing shoes \_\_\_\_\_
Elevating feet \_\_\_\_\_ Hanging feet over side of bed \_\_\_\_\_
Applying ice \_\_\_\_\_ Special shoes (type \_\_\_\_\_) \_\_\_\_\_
Rubbing my feet \_\_\_\_\_ Other \_\_\_\_\_

FREQUENCY OF PAIN: check one or more. None 
Some pain is always present \_\_\_\_\_
Frequency of pain depends on activities \_\_\_\_\_

FREQUENCY OF SWELLING: check one or more. None 
Some swelling is always present \_\_\_\_\_
Frequency of swelling depends on activities \_\_\_\_\_

FREQUENCY OF INSTABILITY: check one or more. None 
(For patients with ankle problems: Instability means that the ankle feels as though it will give out, actually gives out, or "resprains.")
Walking on uneven surfaces  Playing sports  Type of sports? \_\_\_\_\_
Instability occurs several times a week  a month  a year 
Instability is becoming more frequent  less frequent

AIDS FOR WALKING: (used frequently) check one or more. None 
Wheelchair  Crutches  Cane  Other \_\_\_\_\_

# BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

## ACTIVITY LIMITATIONS

Regular Activities **Prior** To Pain /Injury (Check one or more)

**Current** Limitations  
Do with difficulty      Unable to do  
(now)                              (now)

Bicycling-----	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Bowling-----	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Golfing-----	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Running-----	<input type="checkbox"/>	miles/week ____ years running ____	<input type="checkbox"/>	<input type="checkbox"/>
Walking-----	<input type="checkbox"/>	miles/week ____ years walking ____	<input type="checkbox"/>	<input type="checkbox"/>
Other sports-----			<input type="checkbox"/>	<input type="checkbox"/>
House/yard work-----	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Usual occupation-----	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other-----			<input type="checkbox"/>	<input type="checkbox"/>

**After walking** \_\_\_\_ blocks or \_\_\_\_ minutes, I have to stop walking because of my symptoms.

**Generally, over time, I'm:**                              Better                               Same                               Worse

Sports (if applicable):    Current Sport \_\_\_\_\_ Position \_\_\_\_\_  
 Level (highschool, club, etc.) \_\_\_\_\_ Team \_\_\_\_\_ Coach \_\_\_\_\_

OTHER BODY AREAS AFFECTED BY MY FOOT/ANKLE INJURY/PROBLEM:                              None   
 How Related

Head-----	<input type="checkbox"/>			
Neck-----	<input type="checkbox"/>			
Low Back-----	<input type="checkbox"/>			
Shoulders----- R	<input type="checkbox"/>	L	<input type="checkbox"/>	
Hips----- R	<input type="checkbox"/>	L	<input type="checkbox"/>	
Knees----- R	<input type="checkbox"/>	L	<input type="checkbox"/>	

PREVIOUS INJURIES RELATED TO THIS PROBLEM: (same foot or ankle)                              NONE

Date of previous injury \_\_\_\_/\_\_\_\_ Describe \_\_\_\_\_

When present problem began was this previous problem completely resolved?                              Yes     No

**BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY**  
(General History)

**GENERAL MEDICAL HISTORY**

MEDICAL ILLNESSES/CONDITIONS: NONE  Check as many as are applicable

Gout-----	<input type="checkbox"/>	Bladder problems (type)_____	<input type="checkbox"/>
Psoriasis-----	<input type="checkbox"/>	Seizures-----	<input type="checkbox"/>
Heart disease (type)_____	<input type="checkbox"/>	Stroke-----	<input type="checkbox"/>
High blood pressure-----	<input type="checkbox"/>	Liver disease (hepatitis, etc.)-----	<input type="checkbox"/>
Bad circulation in feet-----	<input type="checkbox"/>	Glaucoma-----	<input type="checkbox"/>
Bad leg veins (Varicose, Phlebitis, DVT)-----	<input type="checkbox"/>	Neurological (type)_____	<input type="checkbox"/>
Bleeding disorder/tendency-----	<input type="checkbox"/>	Psychiatric illness (type)_____	<input type="checkbox"/>
Anemia-----	<input type="checkbox"/>	Cancer (type)_____	<input type="checkbox"/>
Ankle swelling-----	<input type="checkbox"/>	Thyroid disease (type)_____	<input type="checkbox"/>
Lung disease (type, include embolus, asthma, etc.)-----	<input type="checkbox"/>	Hyperthermia (with anesthesia)-----	<input type="checkbox"/>
Stomach/intestinal (type)_____	<input type="checkbox"/>		
Kidney disease (type)_____	<input type="checkbox"/>		
Arthritis, Degenerative-----	<input type="checkbox"/>		
Arthritis, Rheumatoid (Blood Test Postive)-----	<input type="checkbox"/>	Age at onset ___ Years	
Arthritis, Other (Lupus, etc.) (type)_____	<input type="checkbox"/>	Age at onset ___ Years	
Diabetes-----	<input type="checkbox"/>	Age at onset ___ Years	Insulin Yes <input type="checkbox"/> No <input type="checkbox"/>

Other \_\_\_\_\_

WOMEN ONLY:

Not pregnant  Possibly pregnant  Definitely pregnant

Pre Menopausal  Post Menopausal

CURRENT MEDICATIONS: NONE

Name of medication (Include Insulin)	Dose	Frequency	Duration of use	
			Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____

ASPIRIN (Anacin, Empirin)? Yes  more than 10 tablets/month Yes  less than 10 tablets/month No

PAST STEROIDS: I have taken steroid pills in the past. Yes  No

HAVE YOU RECEIVED A HEPATITIS B VACCINATION? Yes  No  Unsure

LAST TETANUS IMMUNIZATION? Within past 5 years  More than 5 years ago

ALLERGIES: NONE   
(include medicine, adhesive tape, iodine products, xray dyes, foods, etc.)

Medication, etc.	Reactions-----			
	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____

Non Medications \_\_\_\_\_

# BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

## (General History)

OTHER ORTHOPAEDIC PROBLEMS: None

Back <input type="checkbox"/>	Shoulder	R <input type="checkbox"/>	L <input type="checkbox"/>	Arm	R <input type="checkbox"/>	L <input type="checkbox"/>	Hand	R <input type="checkbox"/>	L <input type="checkbox"/>
Neck <input type="checkbox"/>	Hip	R <input type="checkbox"/>	L <input type="checkbox"/>	Knee	R <input type="checkbox"/>	L <input type="checkbox"/>	Leg	R <input type="checkbox"/>	L <input type="checkbox"/>

Describe other

orthopaedic problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OPERATIONS: (other than foot and ankle) NONE

1. Date \_\_\_/\_\_\_/\_\_\_ Type \_\_\_\_\_  
Complications (Including anesthetic)? \_\_\_\_\_
2. Date \_\_\_/\_\_\_/\_\_\_ Type \_\_\_\_\_  
Complications (Including anesthetic)? \_\_\_\_\_
3. Date \_\_\_/\_\_\_/\_\_\_ Type \_\_\_\_\_  
Complications (Including anesthetic)? \_\_\_\_\_
4. Date \_\_\_/\_\_\_/\_\_\_ Type \_\_\_\_\_  
Complications (Including anesthetic)? \_\_\_\_\_

OTHER HOSPITALIZATIONS: (other than for surgery or childbirth) NONE

1. Date \_\_\_/\_\_\_/\_\_\_ Diagnosis \_\_\_\_\_
2. Date \_\_\_/\_\_\_/\_\_\_ Diagnosis \_\_\_\_\_
3. Date \_\_\_/\_\_\_/\_\_\_ Diagnosis \_\_\_\_\_

TOBACCO/ALCOHOL/RECREATIONAL DRUG USE/HIV RISK FACTORS:

- I have never smoked.     I am a smoker. (\_\_\_\_ packs per day)    # Years Smoking \_\_\_\_\_
- I have been a smoker and I stopped smoking in (year) \_\_\_\_\_
- I do not use alcohol.
- I drink alcohol occasionally.
- I drink 3 or more alcoholic beverages per day, several times a week.

Recreational drug use:    Never     Previously     Currently     Type \_\_\_\_\_

Are you at risk for HIV (AIDS)?    Yes     No

If "yes" check all that apply:    Blood transfusion     Drug use     Other  \_\_\_\_\_

FAMILY HISTORY: Do/did any "blood relatives" have any of the following? None to list

Disease	Relationship	Comment
Cancer-----	<input type="checkbox"/>	_____
Heart disease-----	<input type="checkbox"/>	_____
Diabetes -----	<input type="checkbox"/>	_____
Arthritis -----	<input type="checkbox"/>	_____
Bone disease -----	<input type="checkbox"/>	_____
Foot or ankle problem -----	<input type="checkbox"/>	_____
Hyperthermia (with anesthesia)-----	<input type="checkbox"/>	_____
Other-----	<input type="checkbox"/>	_____

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY  
(General History)

SOCIAL HISTORY:

Home members

- Live alone
- Live with family members (relationship(s)) \_\_\_\_\_
- Other \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_ Width \_\_\_\_\_

Right handed  Left handed

PLEASE USE THIS SPACE FOR ADDITIONAL PERTINENT INFORMATION OR SPECIFIC QUESTIONS YOU WISH TO ASK.

\_\_\_\_\_  
Signature of patient, guardian or witness

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

(Work Injury History)

IF INJURED AT WORK, please give the following information:

Name of company \_\_\_\_\_

City \_\_\_\_\_

Length of time with company at time of injury \_\_\_\_\_

Your usual job title \_\_\_\_\_

Job description (Patient's usual job / activities) \_\_\_\_\_

How many hours do/did you stand and/or walk in 8-hour day? \_\_\_\_\_

Carry loads? Never  Occasionally (1/3)  Frequently (2/3)

Usual weight of load: (range) \_\_\_\_\_

Climb? Never  Occasionally (1/3)  Frequently (2/3)

Use foot controls? Never  Occasionally (1/3)  Frequently (2/3)

How long have/had you been doing this type of work? \_\_\_\_\_

What was your job activity at time of injury? \_\_\_\_\_

Your specific location at time of injury? \_\_\_\_\_

Was your supervisor notified of the injury? Yes  No

Relationship with supervisor at time of injury: Good  Fair  Poor

Level of job satisfaction: High  Average  Low

PREVIOUS WORK INJURIES: None

	<u>Date Injured</u>	<u>Diagnosis (note right or left if applicable)</u>	<u>Time off Work</u>
1.	___/___	_____	_____
2.	___/___	_____	_____
3.	___/___	_____	_____
4.	___/___	_____	_____

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY  
(Work Injury History)

CURRENT WORK STATUS:

1. Are you now working? Yes  No

(If "no," skip to question #5)

2. Are you doing the same type of work as before? Yes  No

3. If you are doing different work, please explain: \_\_\_\_\_

4. Did you miss time from work due to the injury? Yes  No

(If "no," skip to question #6)

5. If you missed work, please indicate the periods of missed work.

From (date) \_\_\_\_\_ to \_\_\_\_\_

From (date) \_\_\_\_\_ to \_\_\_\_\_

From (date) \_\_\_\_\_ to \_\_\_\_\_

6. If you have you been on work restrictions, please indicate the periods. None

From (date) \_\_\_\_\_ to \_\_\_\_\_. Type of restriction \_\_\_\_\_

From (date) \_\_\_\_\_ to \_\_\_\_\_. Type of restriction \_\_\_\_\_

From (date) \_\_\_\_\_ to \_\_\_\_\_. Type of restriction \_\_\_\_\_

7. If you are NOT working now, when did you last work? Date \_\_\_\_\_ Not applicable

• If you are NOT working now, is it because of this injury? Yes  No  Not applicable

If "No," list reason for not working. \_\_\_\_\_

• Is your old job still available Yes  No  Not applicable

8. Do you have an attorney involved with this problem? Yes  No

Name of Attorney: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of attorney acquisition \_\_\_\_\_

Reason for attorney acquisition \_\_\_\_\_