Michael Aronow, M.D.

Orthopedic Associates of Hartford, P.C.

(Patient Identification)

Foot and Ankle New Patient Questionnaire

Name: _____ _____ **Sex**: □ Male □ Female

Date of Birth: _____ **Occupation**: _____

Is this a 2nd opinion? □ Yes □ No Is this an □ accident or □ work related injury?

Please list: Family MD:_____ Referring MD:_____
Address:_____ Address:_____
_____ _____
Phone:_____ Phone:_____
Fax:_____ Fax:_____

If a Worker's Compensation case, please give the name of person and address to receive reports: Claim Representative: _____
Insurance Company: _____
Address:_____
_____
Phone: _____

1. Please describe the problem which brings you to this office today: _____
_____
_____
_____
_____
_____

2. How long have you had the problem? _____
_____

3. How did the injury occur or problem begin? _____
_____
_____
_____

4. Have you ever had a similar previous injury? □ Yes □ No
If so, when? _____

5. Have you noticed any of the following changes or deformities in your feet?
□ Bunions □ Corns □ Calluses □ Flatfeet □ Hammer toes □ High arches
□ Toenail deformities □ Foot ulcers □Other _____
_____

6. Did you have flatfeet or any problems with your feet as a child? □ Yes □ No
If so, what? _____
_____

Michael Aronow, M.D.

Orthopedic Associates of Hartford, P.C.

Foot and Ankle New Patient Questionnaire

7. Have you ever received for your foot or ankle problem:
   □ Surgery □ Shoe inserts □ Custom orthotics or braces □ Ankle wraps or braces
   □ Bunion/Hammertoe splint □ Corn pads □ Physical Therapy □ Cortisone shots, if so how many in each foot? _____
   □ MRI □ CT scan □ Medication, if so, what? _____
   _____

8. List in chronological order, with the appropriate dates, all doctors and/or podiatrists you have seen for your problem and any medications, appliances, surgeries or therapy you have received from them: _____
   _____
   _____
   _____
   _____
   _____

9. If you have had foot or ankle surgery, have you been satisfied with the results?
   □Yes □ No If no, why not? _____
   _____
   _____
   _____
   _____

10. How would you describe the pain: □ None □ Mild □ Moderate □ Severe □ Sharp
    □ Dull □ Burning □ Other, describe_____

11. When does the pain occur? □ In the morning □ At night □ At rest □ With standing
    □ With exercise □ After exercise □ Other _____
    _____

12. Do you have any swelling in your foot or ankle? □ Yes □ No
    If so, where? _____
    _____

13. Do you have numbness of loss of sensation in your leg or foot? □Yes □ No
    If so, where? _____
    _____

14. What (including different types of shoes) makes the pain/symptoms worse?
    _____
    _____

15. What (including different types of shoes) makes the pain/symptoms better?
    _____

Michael Aronow, M.D.

Orthopedic Associates of Hartford, P.C.

Foot and Ankle New Patient Questionnaire

16. Are there any activities that you can no longer perform because of your problem?

_____
_____
_____
_____

17. Have you lost time from work due to your problem? □ Yes □ No
If so, how much? _____

18. Have you ever had a disability rating: □ Yes □ No If so, describe % _____

19. Do you have any work limitations?

_____
_____
_____

MEDICAL/SURGICAL HISTORY

What is your current height? _____ and weight? _____

Allergies: Do you have any allergies to medications: □ Yes □ No
If yes, please list the drug and type of reaction (hives, itching etc.)

_____
_____
_____
_____
_____
_____

Current Medications: List all prescription, over the counter, and herbal medications that you are taking, please include the amount/dosage:

_____
_____
_____
_____
_____
_____

Surgical History: List all the operations that you have had in your life, include the date:

_____
_____
_____
_____
_____
_____

Michael Aronow, M.D.

Orthopedic Associates of Hartford, P.C.

Foot and Ankle New Patient Questionnaire

Review of Systems: Any current or recent problems with the following:

	Yes	No	Describe your answers
Eyes, Vision	□	□	
Ears, Nose, Throat	□	□	
Breathing Difficulties	□	□	
Chest Pain	□	□	
Digestion, GI Problems	□	□	
Bowel, Bladder Problems	□	□	
Blood Transfusions	□	□	
Blackouts, Fainting	□	□	
Muscle Weakness	□	□	
Muscle Spasms, Cramps	□	□	
Balance Problems	□	□	
Numbness, Tingling	□	□	
Psychological Problems	□	□	
Weight Loss or Gain	□	□	
Fevers or Chills	□	□	
Night Sweats	□	□	
Infections	□	□	
Other	□	□	

Medical Problems: Check all of the medical problems you have had in your lifetime:

□	Anxiety or Depression	□	Arthritis-Osteoarthritis/ Post-traumatic	□	Arthritis-Rheumatoid/ Psoriatic/Lupus
□	Asthma	□	Bleeding Disorder	□	Blood Clots
□	Cancer (state type below)	□	Diabetes	□	Gastric Reflux (GERD)
□	Heart Attack	□	Heart Disease	□	Irregular Heart Rhythm
□	Hepatitis □ A □ B □ C	□	High Blood Pressure	□	High Cholesterol
□	HIV/AIDS	□	Kidney Disease	□	Lung Disease
□	Multiple Sclerosis	□	Osteoporosis	□	Parkinson's Disease
□	Peripheral Vascular Disease	□	Polio	□	Seizures
□	Sleep Apnea	□	Stomach Ulcer	□	Stroke
□	Thyroid Disease	□	Traumatic Brain Injury	□	Tuberculosis (TB)
□	Obstructive Sleep Apnea	□	Snoring	□	Daytime somnolence

Please list any other medical problems:

Michael Aronow, M.D.

Orthopedic Associates of Hartford, P.C.

Foot and Ankle New Patient Questionnaire

Social History:

Do you currently use tobacco? □ Yes □ No
Did you previously use tobacco? □ Yes □ No
□ Cigarettes _____packs/day □ Pipe □ Cigar □ Chewing tobacco
For how long? _____yrs When did you quit? _____

Do you drink alcohol? □ Yes □ No How often? _____

History of substance abuse? □ Yes □ No What substance?_____

Family History: Do you have any blood relatives with any of the following conditions?
(Please indicate family member i.e. Mother =M, Father =F, Brother =B, Sister =S)

□	Arthritis	□	Asthma	□	Blood Clots
□	Cancer	□	Diabetes	□	Heart Disease
□	High Blood Pressure	□	Peripheral Vascular Disease	□	Stroke
□	Bunions	□	Hammertoes	□	Foot Ulcers
□	Flatfeet	□	High Arch Feet	□	

Other foot and ankle disorders

_____

_____

_____

Patient's or Guardian's Signature:_____ Date_____

MD Signature:_____Date_____

VITALS: Temp_____ BP_____ HR_____ HT_____ WT_____

Medical Assistant Signature:_____ Date_____

Michael Aronow, M.D.

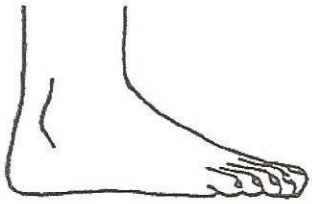
Orthopedic Associates of Hartford, P.C.

Foot and Ankle New Patient Questionnaire

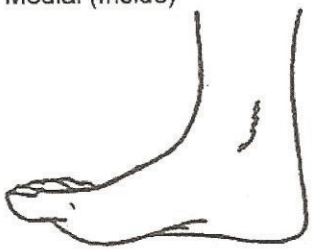
On the diagrams below, please mark the location of your pain

RIGHT FOOT

Lateral (Outside)



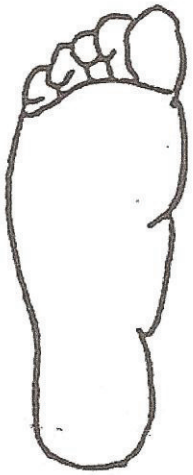
Medial (Inside)



Front

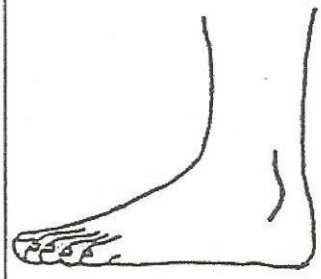
Back

Plantar (Bottom)

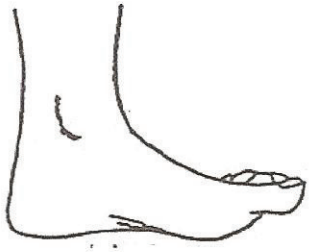


LEFT FOOT

Lateral (Outside)



Medial (Inside)



Front

Back

Plantar (Bottom)