

PATIENT INFORMATION

Kerlan - Jobe
Orthopaedic Clinic

(Please Print Legibly)

CHART # _____ **PHYSICIAN** _____ **DATE** _____

Patient Name (Last) _____ (First) _____ (Middle) _____

Social Security # _____ Driver's License # _____ State _____

Date of Birth: _____ Age: _____ Sex: ___M ___F Marital Status: ___S ___M ___D ___W

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Business # _____ Occupation _____

Spouse's Name _____ DOB _____ SSN _____

Emergency Contact (other than home) _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Relationship _____

Employer _____ **Occupation:** _____

Address _____

City _____ State _____ Zip _____ Phone# _____ ext _____

Employer (spouse) _____ **Occupation:** _____

Address _____

City _____ State _____ Zip _____ Phone# _____ ext _____

INSURANCE

Primary: _____

Secondary: _____

Name of Insured _____

Name of Insured _____

Date of Birth _____

Date of Birth _____

Relationship 1=self, 2=spouse, 3=child, 4=other

Relationship 1=self, 2=spouse, 3=child, 4=other

ID# _____

ID# _____

Group Name _____

Group Name _____

Group # _____

Group # _____

IF PATIENT IS A MINOR OR A STUDENT

School Name, Address and Phone # _____

Father's Name _____

Date of Birth _____ SS# _____

Address _____

City _____ State _____ Zip _____

Employer _____

Work # _____ Ext _____

Mother's Name _____

Date of Birth _____ SS# _____

Address _____

City _____ State _____ Zip _____

Employer _____

Work # _____ Ext _____

FOOT AND ANKLE HISTORY QUESTIONNAIRE

Kerlan-Jobe Orthopaedic Clinic

Date: ____ / ____ / ____

Name: _____ DOB: _____ AGE: _____

Sex: M F Height: _____ Weight: _____ Dominant Hand: R L

Occupation: _____

Currently Working? Y N → if NO, date last worked: ____ / ____ / ____

Referring Doctor(s): _____

(CC) Reason for visit: _____

Location of pain: Right Left ANKLE FOOT HEEL ARCH TOE Other: _____

Date of injury/condition onset of symptoms: ____ / ____ / ____ Is this case going to litigation? Y N

Symptoms related to? work Y N sport Y N (type: _____) other: _____

How did the injury/condition occur? _____

List any previous related injury/condition: _____

Severity of pain (please circle): 0(*least*) 1 2 3 4 5(*moderate*) 6 7 8 9 10(*worst*)

Character of pain (circle all that apply):
dull sharp achy burning throbbing cramping shooting stabbing incapacitating

Other: _____

When do you feel pain? morning afternoon evening working resting sleeping bending climbing squatting

Other: _____

How long does the pain last? morning afternoon evening all-day

Other: _____

Associated symptoms? swelling bruising tenderness giving-way locking fatigue numbness tingling radiation

Other: _____

What improves your symptoms? rest heat cold elevation medication injection braces orthotics

Other: _____

List activity limitations: _____

Previous tests or treatment for this condition:

Test	Result	Treatment	Result/Benefit
◆ X-Ray	Y N _____	◆ Physical Therapy	Y N _____
◆ CT	Y N _____	◆ Orthotics	Y N _____
◆ MRI	Y N _____	◆ Braces	Y N _____
◆ Nerve test/EMG	Y N _____	◆ Injection(s)	Y N _____

◆ Medication(s) (List): _____

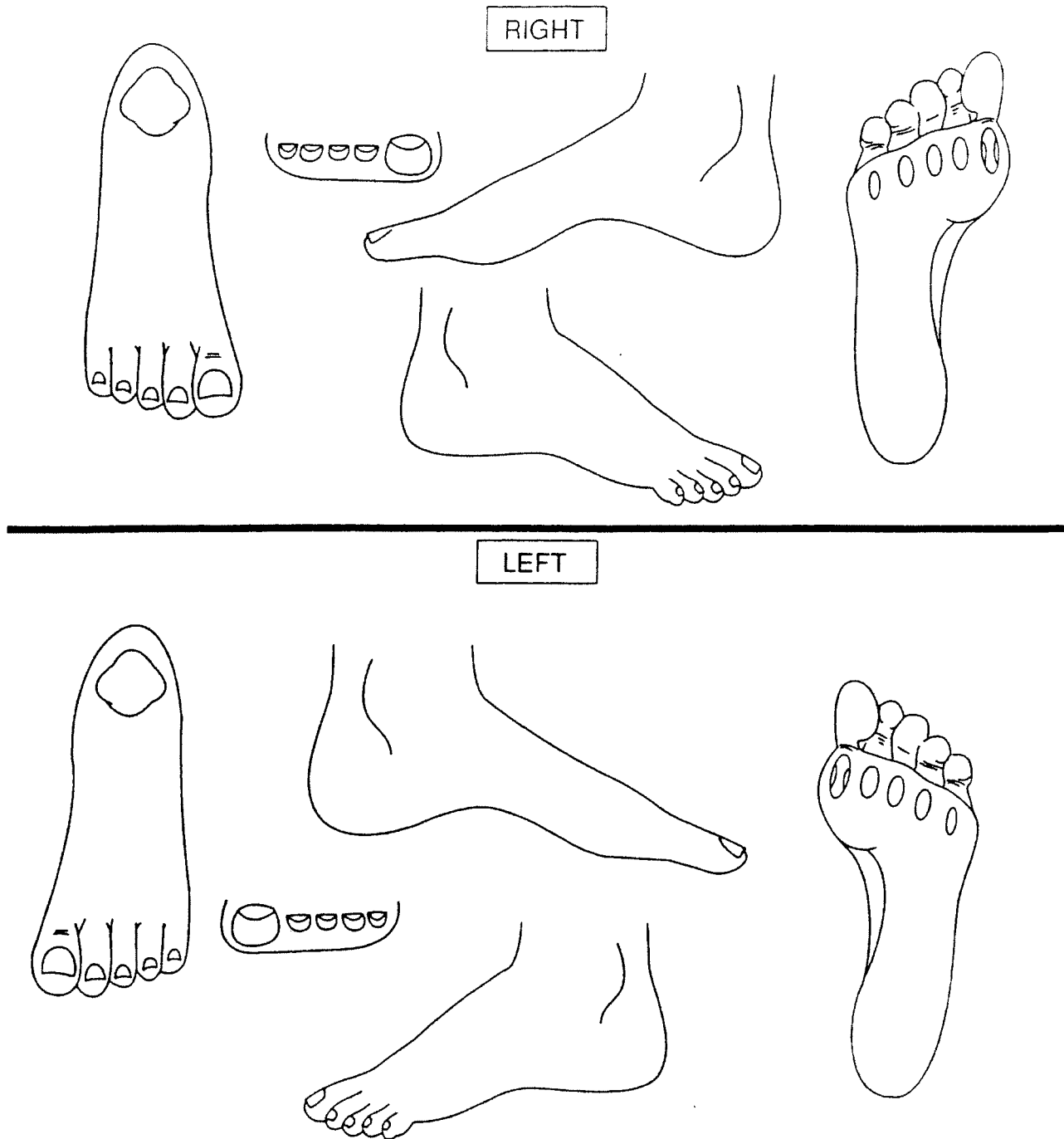
◆ Previous Foot & Ankle surgeries (please list procedures & dates): _____

Name(s) of previous physician(s) who treated this condition: _____ Dates: _____

Using the pain diagram below, mark the location(s) of your pain with:

X's

Also, indicate the severity of pain using the following scale: **1 = MILD 2 = MODERATE 3 = SEVERE**



Patient Statement:

To the best of my knowledge, the Patient History Questionnaire is accurate & complete.

Patient Signature: _____ Date: ____ / ____ / ____

Reviewed by: _____ Date: ____ / ____ / ____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates: () None: _____

Current Medical History Please circle Yes or No if you have any of the following medical problem?

High Blood Pressure	Y	N	Diabetes	Y	N	Heart Trouble	Y	N
Respiratory Problems	Y	N	Stroke	Y	N	Cancer	Y	N
Bleeding Problems	Y	N	HIV/AIDS	Y	N	Other Problems	_____	
Pulmonary Embolism	Y	N	Blood Clot	Y	N	_____		
Gastrointestinal Problems	Y	N	Other	_____				

Current Medications: NONE ()

MEDICATION NAME	DOSAGE	FREQUENCY

Allergies: () None () Contrast/Dye () Sulfa () Penicillin () Local Anesthetics () Latex () Iodine () Shellfish Other: _____

Family History: Please list any FAMILY history medical problems: (i.g. Heart Disease, Stroke, Diabetes, Cancer)

Father: _____ Mother: _____
Siblings: _____ Other: _____

Social History:

Marital Status: Single Married Separated Widowed Divorced Partner
Tabacco Use: Never Packs/day _____ How Many Years? _____ Quit/When _____
Alcohol Use: Never Rarely Moderate Daily How Much? _____
Drug Use: (Prescription & Non Prescription) Never Type & Frequency Recovery Program? Y N When?

Highest level of education: () High School () College () Trade School () Graduate School () Professional School

REVIEW OF SYSTEMS (ROS) Please circle Yes or No if you have any of the following problem?

<p>Constitutional</p> <p>Good General Health N Y</p> <p>Recent Weight Change N Y</p> <p>Night Sweats, Fevers N Y</p> <p>Fatigue N Y</p> <p>Cardiovascular</p> <p>Chest Pain N Y</p> <p>Palpitations N Y</p> <p>Heart Trouble N Y</p> <p>Swelling hands/feet N Y</p> <p>Musculoskeletal</p> <p>Muscle pain or cramps N Y</p> <p>Stiffness/swelling joints N Y</p> <p>Joint pain N Y</p> <p>Trouble walking N Y</p> <p>Endocrine</p> <p>Excessive thirst/urination N Y</p> <p>Thyroid disease N Y</p> <p>Hormone Problem N Y</p> <p>Genitourinary-Male Only</p> <p>Blood in urine N Y</p> <p>Kidney Stone N Y</p> <p>Sexual problems N Y</p> <p>Testicular pain N Y</p>	<p>Ears/Nose/Mouth/Throat</p> <p>Hearing loss/ ringing N Y</p> <p>Sinus Problems N Y</p> <p>Nose Bleeds N Y</p> <p>Sore Throat/voice change N Y</p> <p>Respiratory</p> <p>Shortness of Breath N Y</p> <p>Cough N Y</p> <p>Wheezing/Asthma N Y</p> <p>Coughing up Blood N Y</p> <p>Neurological</p> <p>Frequent headaches N Y</p> <p>Paralysis or tremors N Y</p> <p>Convulsion/seizures N Y</p> <p>Numbness/tingling N Y</p> <p>Hematologic/Lymphatic</p> <p>Bruise easily N Y</p> <p>Slow to heal N Y</p> <p>Enlarged glands N Y</p> <p>Genitourinary-Female Only</p> <p>Blood in urine N Y</p> <p>Kidney Stone N Y</p> <p>Sexual problems N Y</p> <p>Menstrual problems N Y</p>	<p>Eyes</p> <p>Wear glasses/contacts N Y</p> <p>Blurred/double vision N Y</p> <p>Eye disease or injury N Y</p> <p>Glaucoma N Y</p> <p>Gastrointestinal</p> <p>Nausea/vomiting N Y</p> <p>Abdominal Pain N Y</p> <p>Rectal bleeding N Y</p> <p>Bowel Problems N Y</p> <p>Integumentary (skin/breast)</p> <p>Change in hair or nails N Y</p> <p>Rashes or itching N Y</p> <p>Breast lump N Y</p> <p>Breast pain or discharge N Y</p> <p>Allergic/Immunologic</p> <p>Food Allergies N Y</p> <p>Aspirin Allergies N Y</p> <p>Antibiotic Allergies N Y</p> <p>Psychiatric</p> <p>Insomnia N Y</p> <p>Confusion/memory loss N Y</p> <p>Depression N Y</p>
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