PHYSICIANS' CLINIC
of Iowa, P.C.

ORTHOPAEDIC - FOOT & ANKLE QUESTIONNAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Occupation _____ Gender: ☐ Male ☐ Female

HISTORY

Which foot/ankle is causing the problem? ☐ Right ☐ Left ☐ Both

Main reason for your visit: _____

_____

How long has this problem existed? _____

What is the most disabling aspect of the problem? _____

_____

Is the problem related to an accident, job, sport, etc.? ☐ Yes ☐ No If yes, please describe _____

_____

What makes the problem better? _____

_____

What makes the problem worse? _____

_____

How does your problem affect your exercise program, job, or daily activities? _____

_____

What kind of trouble are you having with shoes? (i.e. buying, wearing, modifying, etc.) _____

_____

What style or type of shoe is most comfortable for you? _____

TREATMENT & MEDICATIONS

What type of orthosis (i.e. arch supports, inserts, etc.) have you tried? _____

Have any of these helped the problem? ☐ Yes ☐ No

Have you used any medications for the problem? ☐ Yes ☐ No If yes, please list below.

Name of Medication	Dose	Frequency

Have any of the above medications helped the problem? ☐ Yes ☐ No If yes, please list which one _____

Please list the names of other health care providers you have seen for this problem or the podiatrist that referred you:

Physician	Specialty	City	Treatments

Please list any past surgeries related to your problem:

Surgery	Physician	When

OTHER COMMENTS _____

_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____