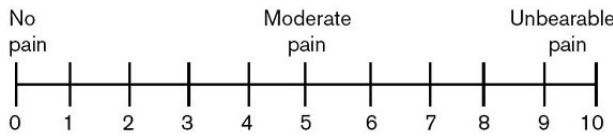



Name:

Age:

Date:

What side is the problem? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	Patient Sticker
Height: Weight:	
Circle a number from 0-10 that best describes how much pain you are having RIGHT NOW . <div style="display: flex; justify-content: space-between; width: 100%;"> <div style="text-align: center;">No pain</div> <div style="text-align: center;">Moderate pain</div> <div style="text-align: center;">Unbearable pain</div> </div> 	For a child or non-english speaking adult, use the 
FACES© pain rating scale below:	

Please list any ALLERGIES you have to <u>medications or food/substances</u> :	<input type="checkbox"/> None
Please list all prescription medications and the dose that you take (or provide a list):	<input type="checkbox"/> None
Please indicate your preferred pharmacy with name/city/zip:	

When did you start to have pain?	
Was there a specific injury (if so, what happened)?	
Were you able to put weight on the leg after injury: <input type="checkbox"/> Yes <input type="checkbox"/> No Did your ankle pop? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or tingling? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____ Does the pain shoot down into your foot? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list any previous foot or ankle surgeries below:
Where do you feel the pain? <input type="checkbox"/> Front of the ankle <input type="checkbox"/> in the mid-foot <input type="checkbox"/> Back of the ankle <input type="checkbox"/> Arch of the foot <input type="checkbox"/> Outside of the ankle <input type="checkbox"/> Achilles or Heel <input type="checkbox"/> Inside of the ankle <input type="checkbox"/> Other _____	What treatments have you tried: <input type="checkbox"/> None <input type="checkbox"/> NSAIDS (<i>Motrin, Ibuprofen</i>) Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Narcotics (<i>Codeine, Vicodin</i>) Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Physical Therapy Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Injections Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Surgery Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N
What makes the pain better?	

What makes the pain worse? 	How do you describe the pain? <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing
---	---

Occupation?			
What sports/activities do you participate in?			
Sport	Level	Hours/Week	Weeks/Year

Check and explain if you have any of the following:	
<input type="checkbox"/> NONE OF THE BELOW <input type="checkbox"/> Headache, dizziness, visual problems <input type="checkbox"/> Ear, nose or throat problem <input type="checkbox"/> Chest pain, irregular heartbeat, palpitations <input type="checkbox"/> Lung problems, asthma, shortness of breath <input type="checkbox"/> Difficulty or frequent urination <input type="checkbox"/> Nausea, vomiting, diarrhea, heartburn <input type="checkbox"/> Loss of sensation in your arms or legs <input type="checkbox"/> Vascular disease <input type="checkbox"/> Diabetes, thyroid or other endocrine problems <input type="checkbox"/> Easy bruising <input type="checkbox"/> Fevers, chills, night sweats <input type="checkbox"/> Recent weight loss or gain	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Today's Visit at MarinHealth Orthopedic Care:

To ensure you get the most out of your appointment, please list below three main concerns you'd like addressed. (As an example: review imaging studies, discuss medication management, explore non-operative treatments, etc.)

1. _____

2. _____

3. _____

