Patient Registration Information

Name_____

Age_____ Height_____ Weight_____

How were you referred us? □ NYU or SIUH physician referral line

□ Friend

□ Internet/Phone book

□ Dr. _____

Primary Care Physician_____ Phone #_____

Reason for today's visit_____

Is this due to a work injury? Yes No If yes, Date of injury_____

Motor vehicle accident? Yes No

Litigation Pending? Yes No

MEDICAL HISTORY

Asthma Yes No Mental Illness Yes No Cardiac Problems Yes No

Hypertension Yes No Gastric Ulcers Yes No Nature of_____

Stroke Yes No Cancer Yes No _____

Seizure Yes No Rheumatism Yes No

Bleeding Thyroid disorder Yes No

Disorder Yes No Diabetes Yes No

Other_____

PLEASE LIST ALL SURGERIES

_____ Date_____ _____ Date_____

_____ Date_____ _____ Date_____

_____ Date_____ _____ Date_____

_____ Date_____ _____ Date_____

MEDICATIONS

Name	Dose	Name	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Do you have any <u>DRUG ALLERIES?</u> Yes No

If yes, please list_____

Patient Registration Information

FAMILY HISTORY

	Age	Medical Conditions
Father	_____	_____
Mother	_____	_____
Children	_____	_____

SOCIAL HISTORY

Marital Status	single	married	divorced	widowed
Alcohol use	never	rarely	moderate	daily
Tobacco use	never	quit	current; packs per day_____	

Questionnaire for Foot/Ankle Patients

Pain

-None
-Mild, occasional
-Moderate, daily
-Severe, almost always present

Function

-No limitations on any activities
-No limitations on activities of daily living/employment, with limitations on recreational activities
-Limited daily and recreational activities / needs cane to walk
-Severe limitation of daily and recreational activities / needs crutches, walker or wheelchair

Maximum walking distance

-Greater than 6 blocks
-4-6 blocks
-1-3 blocks
-Less than one

Walking surfaces

- No difficulty, any surface
-Some difficulty on uneven terrain, stairs, inclines, ladders
-Sever difficulty on uneven terrain, stairs, inclines, ladders

Footwear requirements

-Fashionable, conventional shoe, no insert (orthotic) needed
-Comfort footwear and/or shoe insert
-Modified shoes or brace

Pain Scale (please mark pain level over past week)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst)