MAGIC VALLEY ORTHOPEDICS

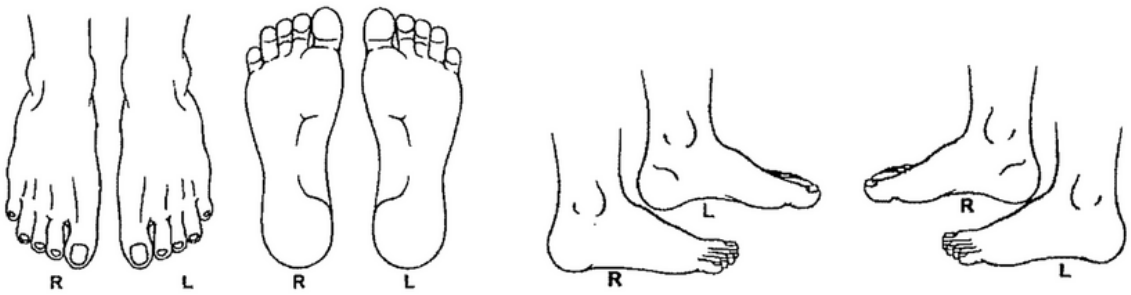
Dr. Ryan Callahan

Foot & Ankle Patient Form

Patient Name: _____ Date of Birth:_____Today's Date:_____

Describe injury/location/duration of pain (mark the diagrams below to show location):

_____



Current problem is the result of a(n): (Check all that apply)

☐ Car accident ☐ Work Accident ☐ Accident ☐ Other: _____

Pain Scale (None to Extreme) 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? ☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Electric Shock

What improves your pain? ☐ Rest ☐ Splinting/Bracing ☐ Pain Meds ☐ Other: _____

What makes your pain worse? ☐ Standing ☐ Walking ☐ Stairs ☐ Uneven Surfaces ☐ Other: _____

Are you using any type of assistance (i.e. crutches, walker, wheelchair? ☐ Yes ☐ No

If yes, what?: _____ Why? _____

Have you been diagnosed with Diabetes? (Type I or Type II)	☐ Yes	☐ No
Do you currently smoke or use any nicotine products?	☐ Yes	☐ No
Have you been diagnosed with Rheumatoid Arthritis?	☐ Yes	☐ No
Have you been diagnosed with blood clots? (DVT or PE)	☐ Yes	☐ No
Do you have/or ever been diagnosed with MRSA or had a MRSA nasal swab?	☐ Yes	☐ No
Have you ever had general anesthesia?	☐ Yes	☐ No
Have you ever had problems with anesthesia?	☐ Yes	☐ No

(if yes) Describe: _____