MR SIMON E SMITH

Podiatric Surgeon – Reconstructive Foot Surgery

Patient Questionnaire

Patient Name: Date:

Please describe reason for attending:

Where does it hurt?

How long have you had the problem?

What relieves the pain? What makes it worse?

Please describe the type of PAIN you have
(check all that apply)

☐ Sharp ☐ Aching ☐ Stabbing

☐ Dull ☐ Cramping ☐ Throbbing

☐ Pins & Needles ☐ Constant ☐ Comes & goes

On a scale of 1-10, how severe is the pain? (please circle)

No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

If it is an injury when did it happen?

How did it happen?

Where did it occur? (e.g. Home, Business)

What studies have you had? ☐ X-rays ☐ CT ☐ MRI ☐ Bone Scan ☐ Ultra Sound ☐ Other

Have you had previous surgery for this injury or problem? If "YES" include when, where, name of surgeon and did the surgery help.

Medical History

Please check all that apply:

☐ Anaemia
☐ Diabetes
☐ Gout
☐ Bleeding/bruising tendency
☐ Cancer
☐ Stroke
☐ Osteoporosis
☐ Heart Condition
☐ Thyroid
☐ Irregular Heartbeat
☐ Seizures
☐ Heart Attack
☐ High Blood Pressure
☐ Asthma/ Emphysema/ wheezing
☐ Phlebitis
☐ Pulmonary Embolism
☐ Alcoholism
☐ Blood Clots
☐ Hepatitis
☐ Sleep Apnoea
☐ Fibromyalgia
☐ Kidney Transplant or Dialysis
☐ Chronic Back Pain
☐ Rheumatoid Arthritis
☐ Depression/ Anxiety
☐ Stomach Ulcers or Reflux
☐ Other

Systems Review

Please check all that apply (recent or current only):

☐ Loss of Appetite
☐ Weight Loss
☐ Blurred Vision
☐ Fatigue
☐ Ringing in Ears
☐ Nose Bleeds
☐ Pain with swallowing
☐ Cold hands or feet
☐ Swelling of Feet
☐ Fainting
☐ Incontinence
☐ Frequent Urination
☐ Balance Problems
☐ Memory Loss
☐ Co-ordination Problems
☐ Dizziness
☐ Headaches
☐ Tremors
☐ Muscle Weakness
☐ Muscle Cramps
☐ Joint Stiffness/Swelling
☐ Joint Pain
☐ Nausea
☐ Diarrhea
☐ Fever
☐ Double Vision
☐ Constipation
☐ Vomiting

Please list any medications you are now taking, both prescription and over the counter.

Name of Medication	Dosage (eg. 10mg)	How often do you take (eg. once daily)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Do you have any allergies? Please list and describe the reaction below

Past family history – Please tick the box of any of the following medical problems anyone of your immediate family (mother, brother, father, sister, grandparents) has had:

Complications

☐ ☐Arthritis ☐ Diabetes ☐ Heart Problems ☐ Problems with Anaesthesia ☐ Bleeding Problems

☐ Blood Clots ☐ Foot Problems

List all past surgeries you have had, including any complications, e.g. bleeding, infection, blood clots, etc. (including the year)

Surgeries (& Date)	Complications
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Have you had problems with a previous anaesthetic? ☐ Yes ☐ No

Please list and describe the reaction:

Social History

Do you exercise regularly? ☐ No ☐ Yes (what type and how often) -

Do you smoke? ☐ No ☐ Yes (how many per day) -

Do you drink alcohol? ☐ No ☐ Yes (how many units per week) -

What is your occupation?

Your height? Your weight?

Do you live alone? ☐ No ☐ Yes

If Yes, do you have someone close to you that can help you recuperate? ☐ No ☐ Yes