



37735

ALLERGIES/MEDICATIONS/SURGERIES/SOCIAL

ALLERGIES NONE

(1)																				
(2)																				
(3)																				
(4)																				
(5)																				

(6)																				
(7)																				
(8)																				
(9)																				
(10)																				

MEDICATIONS NONE

(1)																				
(2)																				
(3)																				
(4)																				
(5)																				
(6)																				
(7)																				
(8)																				
(9)																				
(10)																				

	DOSE	HOW MANY TIMES A DAY

OPERATIONS/SURGERIES NONE

(1)																				
(2)																				
(3)																				
(4)																				
(5)																				
(6)																				
(7)																				
(8)																				
(9)																				
(10)																				

PHYSICIAN/LOCATION YEAR

SMOKING

No, I quit in the past 6 months
 No, I quit more than 6 months ago
 I never smoked
 YES

If yes, how much per day?

ALCOHOL

I drink alcohol
 Occasionally Rarely
 Daily Never

How much?

Chew Tobacco or Dip Snuff

No Yes

I have children. Yes No

Age Range

I am currently working. Yes No

I am on disability or am applying. Yes No

I live with someone who can take care of me. Yes No

Attorney associated with this condition? Yes No

Attorney Name:

Address:

City: St: Zip:

Telephone:



49928

FOOT & ANKLE QUESTIONNAIRE

Please answer the following questions for the foot/ankle being treated or followed up. If it both feet/ankles, please answer the questions for your worse side. All questions are about how you felt, on average, during the past week. If you are being treated for an injury that happened less than one week ago, please answer for the period since your injury.

During the past week how **STIFF** was your foot/ankle? (Check one response)

Not at all Mildly Moderately Very Extremely

During the past week how **SWOLLEN** was your foot/ankle? (Check one response)

Not at all Mildly Moderately Very Extremely

During the past week, please tell us about how painful your foot/ankle was during the following activities. (Circle **ONE** response on each line that best describes your average ability.)

	<u>Not painful</u>	<u>Mildly painful</u>	<u>Moderately painful</u>	<u>Very Painful</u>	<u>Extremely painful</u>	<u>Could not do because of foot/ankle pain</u>	<u>Could not do for other reasons</u>
Walking on uneven surfaces?	1	2	3	4	5	6	7
Walking on flat surfaces?	1	2	3	4	5	6	7
Going up or down stairs?	1	2	3	4	5	6	7
Lying in bed at night?	1	2	3	4	5	6	7

During the past week, did your foot/ankle give way during the following activities. (Circle **ONE** response on each line that best describes you for each average level.)

	<u>Did not give way at all</u>	<u>Partially gave way, but I did not fall</u>	<u>Completely gave way, but I did not fall</u>	<u>Could not do the activity because of foot/ankle giving way</u>	<u>Could not do for other reasons</u>
Strenuous activity, such as heavy physical work, skiing, tennis?	1	2	3	4	5
Moderate activity, such as moderate physical work, jogging, running?	1	2	3	4	5
Light activity, such as walking, house work or yard work?	1	2	3	4	5

Which of the following statements **BEST** describes your ability to get around most of the time during the past week (Check one response)

- I did not need support or assistance at all.
- I mostly walked without support or assistance.
- I mostly used one cane or crutch to help me get around.
- I mostly used two canes, two crutches or a walker to help me get around.
- I used a wheelchair.
- I mostly used other supports or someone else had to help me get around.
- I was unable to get around at all.



FOOT & ANKLE QUESTIONNAIRE

How much trouble did you have with balance during the past week? (Check one response)

- No trouble at all
- A little bit of trouble
- A moderate amount of trouble
- Quite a bit of trouble
- A great amount of trouble
- I cannot balance on my feet at all

How much difficulty do you have walking on uneven surfaces (eg. small stones, rocks, sloping ground)? (Check one response)

- No difficulty
- Mild difficulty
- Moderate difficulty
- Severe difficulty
- Extreme difficulty
- Cannot do because of foot/ankle
- Cannot do for other reasons

How difficult was it for you to put on or take off socks/stockings during the past week? (Check one response)

- Not at all difficult A little bit difficult Moderately difficult Very difficult Extremely difficult Cannot do at all

During the past week, please tell us about how painful your foot/ankle was during the following activities. (Circle ONE response on each line that best describes your average ability.)

	<u>No pain</u>	<u>Mild pain</u>	<u>Moderate pain</u>	<u>Severe Pain</u>	<u>Extreme pain</u>	<u>Could not do because of foot/ankle pain</u>	<u>Could not do for other reasons</u>
Strenuous activity, such as heavy physical work, skiing, tennis	1	2	3	4	5	6	7
Moderate activity, such as moderate physical work, jogging, running	1	2	3	4	5	6	7
Light activity, such as walking, house work, yard work	1	2	3	4	5	6	7
Standing for an hour	1	2	3	4	5	6	7
Standing for an hour	1	2	3	4	5	6	7

How much do you like the appearance of your foot? (Check one response)

- I like it a lot I like it somewhat I am neutral or I don't care I dislike it somewhat I dislike it a lot

How much did your foot or ankle problem interfere with your normal work, including work both outside the home and house work? (Check one response)

- Not at all A little bit Moderately Quite a bit Extremely Unable to work due to foot and ankle problems

**FOOT & ANKLE QUESTIONNAIRE**

How much did your foot or ankle problem interfere with your life and your ability to do what you want? (Check one response)

Not at all A little bit Moderately Quite a bit Extremely It ruins everything

How often do you wear the following kinds of shoes? (Circle ONE response on each line.)

	<u>NEVER</u>	<u>SOMETIMES</u>	<u>OFTEN</u>
Any women's shoe (including high heels) OR any men's shoe (including fancy dress shoes)	1	2	3
Most women's dress shoes (except high heels) OR most men's dress shoes	1	2	3
Sneakers, walking or casual shoes	1	2	3
Orthopaedic or Prescription shoes	1	2	3

What types of shoes can you wear comfortably? (Circle ONE response on each line.)

	<u>YES</u>	<u>NO</u>	<u>NOT APPLICABLE</u>
Any women's shoe (including high heels) OR any men's shoe (including fancy dress shoes)	1	2	3
Most women's dress shoes (except high heels) OR most men's dress shoes	1	2	3
Sneakers, walking or casual shoes	1	2	3
Orthopaedic or Prescription shoes	1	2	3
All shoes	1	2	3



PATIENT MODEMS HISTORY

In general would you say your health is:

Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your health in general now:

- Much better than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse than one year ago
- Much worse now than one year ago

The following items are about activities you might do during a typical day.
 Does your health now limit you in these activities? If so, how much?
 (Circle one response on each line.)

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous Activities such as running, lifting heavy objects, or participating in strenuous sports.	1	2	3
Moderate Activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Bending, kneeling or stooping	1	2	3
Walking more than one mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
Bathing or dressing yourself	1	2	3

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
 (Circle one response on each line.)

	Yes	No
Cut down the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the kind of work or other activities	1	2
Had difficulty performing the work or other activities (for example, it took extra effort)	1	2



PATIENT MODEMS HISTORY

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems? (Circle one response on each line.)

	Yes	No
Cut down the <u>amount of time</u> you spent on work or other activities	1	2
<u>Accomplished less</u> than you would like	1	2
Did not do work or other activities as <u>carefully</u> as usual	1	2

During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? (Check one response)

Not at all Slightly Moderately Quite a bit Extremely

How much bodily pain have you had during the past four weeks? (Check one response)

None Very mild Mild Moderate Severe Very Severe

During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Check one response)

Not at all Slightly Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past four weeks? (Circle one response on each line.)

	All of the Time	Most of the Time	A good bit of the Time	Some of the Time	A little of the Time	None of the Time
Did you feel full of pep?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired?	1	2	3	4	5	6



39440

PATIENT MODEMS HISTORY

During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Check one response)

All of the time Most of the time Some of the time A little of the time None of the time

Please choose the answer that best describes how true or false each of the following statement is for you. (Circle one response on each line.)

	<u>Definitely true</u>	<u>Mostly true</u>	<u>Not sure</u>	<u>Mostly False</u>	<u>Definitely False</u>
I seem to get sick a little easier than other people.	1	2	3	4	5
I am as healthy as anyone I know	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5

During the past week, how often have you taken pain medication, including narcotics or over-the-counter medications? (Check one response)

Three or more times a day Once or twice a day Once every couple of days Once a week Not at all

Do you smoke cigarettes? (Check one response)

Yes No, I quit in the last six months No, I quit more than six months ago I have never smoked

What results do you expect from your treatment? (Circle one response on each line.)

	<u>Not at all likely</u>	<u>Slightly likely</u>	<u>Somewhat likely</u>	<u>Very Likely</u>	<u>Extremely likely</u>	<u>Not applicable</u>
Relief from symptoms (pain, stiffness, swelling, numbness, weakness, instability)	1	2	3	4	5	6
To do more everyday household or yard activities	1	2	3	4	5	6
To sleep more comfortably	1	2	3	4	5	6
To go back to my usual job	1	2	3	4	5	6
To exercise and do recreational activities	1	2	3	4	5	6
To prevent future liability	1	2	3	4	5	6

If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it? (Check one response)

Very dissatisfied Somewhat dissatisfied Neutral Somewhat satisfied Very satisfied