HPI FOOT & ANKLE

Form Reviewed By: _____ Date: _____ Time: _____

Name: _____ Sex: Male _____ Female _____

Shoe Size: _____ Height: _____ Weight: _____ Age: _____

History of Patient Illness:

1. What specific problem brings you to our office today?
   _____
   _____

2. Where is the pain/condition located?
   Left Foot/Ankle _____ Right Foot/Ankle _____ Both _____

3. How long ago did this problem start? _____

4. How would you describe the nature of your pain?

Sharp	_____	Burning	_____	Stabbing	_____
Dull	_____	Radiating	_____	Throbbing	_____
Aching	_____	Itching	_____	Soreness	_____
Other	_____				

5. What seems to make the pain/condition feel worse?

Walking	_____	Flat Shoes	_____
Standing	_____	Any Closed Shoes	_____
Resting	_____	Daily Activities	_____
Exercise	_____	Dress Shoes	_____

6. What makes the condition feel better? _____
   _____

7. What treatments have you tried for this condition? _____
   _____

8. Do you participate in competitive sports? Yes _____ No _____

9. Is this problem a result of an injury? Yes _____ No _____
   If yes, what is the date of injury? _____ / _____ / _____
   Where did the injury occur? _____
   _____

   If the injury occurred at work, has your employer been notified? Yes _____ No _____

Employer: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer Phone Number: _____ Contact Person: _____

Patient Signature: _____ Received By: _____ Date: _____