

Welcome to Georgia Foot & Ankle Specialists

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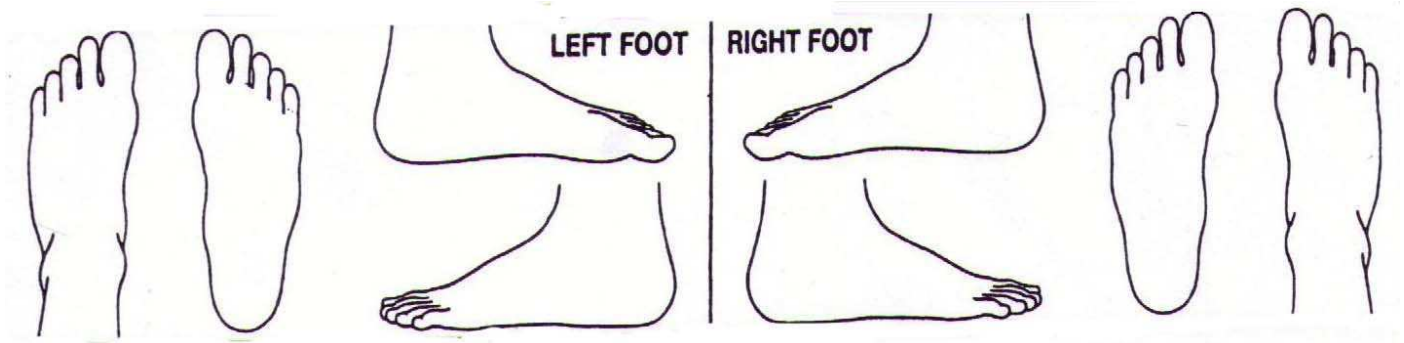
Name: _____ DOB: ____/____/____

Describe your primary foot or ankle concern:

Brief description of the concern: _____

___right foot ___left foot ___right ankle ___left ankle ___right leg ___left leg ___toes

Please locate the pain on the following diagrams:



If you have pain, describe the nature of the pain:

___dull ___ache ___sharp ___electrical ___burning ___numbing ___tingling

other: _____

How often does it hurt or affect you?

___at all times ___daily ___weekly ___worse at night ___worse in morning

other: _____

How long has been (enter number)? #:____ days #:____ weeks #:____ months #:____ years

How has the issue progressed: ___about the same ___getting better ___getting worse

Describe any treatment for this problem: _____

Does anything make it worse? _____

Does anything make it better? _____

Are there any hobbies or activities that are restricted? _____

Shoe Size: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Retained hardware: ___Yes ___No

Who referred you to our office? ___Physician ___Patient ___Friend/family

___Phonebook ___Website ___Radio Ads ___Insurance co

Medical History - Please check if **you** have any of the following conditions:

___anemia	___diabetes type I	___liver disease
___asthma	___diabetes type II	___lupus
___arthritis	___gout	___neuropathy
___back pain	___heart disease	___rheumatoid arthritis
___blood clot	___heart surgery	___stroke
___cancer, breast	___heart valve dx.	___stroke mini (TIA)
___cancer, cervical	___high cholesterol	___ulcer foot
___cancer, stomach	___HIV positive	other: _____
___cancer, skin	___hypertension	other: _____
___carotid disease	___hypothyroidism	other: _____
___depression	___kidney disease	

Family History - Please check if **blood relatives** have any of the following conditions:

___anemia	___diabetes type I	___liver disease
___asthma	___diabetes type II	___lupus
___arthritis	___gout	___neuropathy
___back pain	___heart disease	___rheumatoid arthritis
___blood clot	___heart surgery	___stroke
___cancer, breast	___heart valve dx	___stroke mini (TIA)
___cancer, cervical	___high cholesterol	___ulcer foot
___cancer, stomach	___HIV positive	other: _____
___cancer, skin	___hypertension	other: _____
___carotid disease	___hypothyroidism	other: _____
___depression	___kidney disease	

Surgical History

Foot & Ankle & Leg Surgery

- | | | |
|--|---|---|
| <input type="checkbox"/> Achilles lengthening | <input type="checkbox"/> bypass of leg arteries | <input type="checkbox"/> neuroma |
| <input type="checkbox"/> amputation of foot | <input type="checkbox"/> fibroma removal | <input type="checkbox"/> stents in leg arteries |
| <input type="checkbox"/> amputation of leg | <input type="checkbox"/> ganglion removal | <input type="checkbox"/> toenail removal |
| <input type="checkbox"/> amputation of toe | <input type="checkbox"/> hammertoe repair | <input type="checkbox"/> vein stripping |
| <input type="checkbox"/> ankle fracture repair | <input type="checkbox"/> heel spur removal | <input type="checkbox"/> wart removal |
| <input type="checkbox"/> ankle scope | <input type="checkbox"/> heel plantar fascia | other: _____ |

Knee, Hip, Arm & Spine Surgery

- | | | |
|--|--|--|
| <input type="checkbox"/> arm – elbow surgery | <input type="checkbox"/> knee scope | <input type="checkbox"/> neck surgery fusion |
| <input type="checkbox"/> back surgery disc | <input type="checkbox"/> knee surgery | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> back surgery fusion | <input type="checkbox"/> hip replacement | <input type="checkbox"/> shoulder surgery |
| <input type="checkbox"/> carpal tunnel surgery | <input type="checkbox"/> hip surgery | other: _____ |
| <input type="checkbox"/> knee replacement | <input type="checkbox"/> neck surgery disc | |

Cardiac & Vascular Surgery

- | | | |
|---|---|--|
| <input type="checkbox"/> aneurism aortic | <input type="checkbox"/> carotid surgery | <input type="checkbox"/> stent placement |
| <input type="checkbox"/> aneurism cranial | <input type="checkbox"/> coronary artery bypass | other: _____ |
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> pacemaker | |

General & OBGYN surgery

- | | | |
|--|---|---|
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> c-section | <input type="checkbox"/> laparoscopy (scope) |
| <input type="checkbox"/> breast biopsy | <input type="checkbox"/> gall bladder (chole'y) | <input type="checkbox"/> oophorectomy (ovary) |
| <input type="checkbox"/> breast-mastectomy | <input type="checkbox"/> hernia surgery | <input type="checkbox"/> tonsillectomy (T&A) |
| <input type="checkbox"/> breast tumor (benign) | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> thyroidectomy |
| <input type="checkbox"/> colon surgery | <input type="checkbox"/> laparotomy | other: _____ |

Other Surgery

- | | | |
|---|--|--------------|
| <input type="checkbox"/> brain surgery | <input type="checkbox"/> breast augmentation | other: _____ |
| <input type="checkbox"/> cataract | <input type="checkbox"/> gastric bypass | |
| <input type="checkbox"/> breast reduction | <input type="checkbox"/> laser eye (Lasik) | |

Review of Systems: Please check symptoms **you** are **currently** experiencing

Eyes:

- | | | |
|---|--|---|
| <input type="checkbox"/> cataracts | <input type="checkbox"/> glasses or contact lenses | <input type="checkbox"/> pain or soreness eye |
| <input type="checkbox"/> change in vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> redness |
| <input type="checkbox"/> excess tearing | <input type="checkbox"/> last eye exam | |

General:

- | | | |
|---|----------------------------------|---------------------------------------|
| <input type="checkbox"/> change in weight | <input type="checkbox"/> fever | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> malaise | |

Gastrointestinal:

- | | | |
|--|---|--|
| <input type="checkbox"/> abdomen pain/cramps | <input type="checkbox"/> gall bladder trouble | <input type="checkbox"/> pain after fatty food |
| <input type="checkbox"/> acid reflux | <input type="checkbox"/> heart burn | <input type="checkbox"/> rectal bleeding |
| <input type="checkbox"/> blood in stools | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> swallowing problems |
| <input type="checkbox"/> change in appetite | <input type="checkbox"/> indigestion | <input type="checkbox"/> vomit blood |
| <input type="checkbox"/> constipation | <input type="checkbox"/> jaundice | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> liver trouble | <input type="checkbox"/> watery stools |
| <input type="checkbox"/> excess gas | <input type="checkbox"/> nausea | |

Head:

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> head injury | <input type="checkbox"/> head aches |
|--------------------------------------|-------------------------------------|

Hematological:

- | | | |
|---|---|---|
| <input type="checkbox"/> anemia/low blood count | <input type="checkbox"/> easy bruising-bleeding | <input type="checkbox"/> past transfusion |
|---|---|---|

Review of Systems: Please check symptoms **you** are **currently** experiencing

Immunologic:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> hay fever | <input type="checkbox"/> seasonal allergies |
| <input type="checkbox"/> coughing | <input type="checkbox"/> hepatitis | |
| <input type="checkbox"/> eyes watering | <input type="checkbox"/> HIV positive | |

Lymphatic:

- | | | |
|--|--|--|
| <input type="checkbox"/> hand swelling | <input type="checkbox"/> lymphedema | <input type="checkbox"/> recent transfusion |
| <input type="checkbox"/> leg swelling | <input type="checkbox"/> recent sickle cell crisis | <input type="checkbox"/> swollen lymph nodes |

Mouth & Throat:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> last dental exam | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> hoarseness | <input type="checkbox"/> mouth sores | <input type="checkbox"/> sore tongue |

Muscular:

- | | | |
|---|---|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> leg cramps | <input type="checkbox"/> swelling in joints |
| <input type="checkbox"/> back pain | <input type="checkbox"/> limited motion or activity | <input type="checkbox"/> use of walking aid |
| <input type="checkbox"/> gout | <input type="checkbox"/> muscle or joint pains | <input type="checkbox"/> weakness |
| <input type="checkbox"/> joint redness | <input type="checkbox"/> neck pain | |
| <input type="checkbox"/> joint swelling | <input type="checkbox"/> stiffness | |

Neck:

- | | |
|---------------------------------|---|
| <input type="checkbox"/> goiter | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> lumps | <input type="checkbox"/> swollen glands |

Review of Systems: Please check symptoms **you** are **currently** experiencing

Neurological:

- | | | |
|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> black outs | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling |
| <input type="checkbox"/> burning | <input type="checkbox"/> paralysis | <input type="checkbox"/> tremors |
| <input type="checkbox"/> fainting | <input type="checkbox"/> seizures | <input type="checkbox"/> uncontrolled movements |

Nose & Sinus:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> discharge | <input type="checkbox"/> itching | <input type="checkbox"/> stuffy nose |
| <input type="checkbox"/> frequent colds | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> sinus congestion/trouble |

Psychiatric:

- | | | |
|---|--|--|
| <input type="checkbox"/> anxiety or nervousness | <input type="checkbox"/> depression | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> change in mood | <input type="checkbox"/> forgetful/memory loss | <input type="checkbox"/> psychiatric/emotional |

Reproduction Female:

- | | | |
|--|--|--|
| <input type="checkbox"/> change in period | <input type="checkbox"/> itching | <input type="checkbox"/> post menopause |
| <input type="checkbox"/> complicated pregnancy | <input type="checkbox"/> lumps | <input type="checkbox"/> sexual transmitted dx |
| <input type="checkbox"/> current pregnancy | <input type="checkbox"/> menopause | <input type="checkbox"/> sores |
| <input type="checkbox"/> discharge | <input type="checkbox"/> number of deliveries | |
| <input type="checkbox"/> excess pain with period | <input type="checkbox"/> number of pregnancies | |

Reproduction Male:

- | | | |
|---|--|--|
| <input type="checkbox"/> hernia | <input type="checkbox"/> penile sores | <input type="checkbox"/> testicular mass |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> sexual transmit disease | |

Review of Systems: Please check condition you are currently experiencing

Respiratory:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> emphysema | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> wheezing |
| <input type="checkbox"/> coughing blood | <input type="checkbox"/> exposure to tuberculosis | |
| <input type="checkbox"/> coughing sputum | <input type="checkbox"/> shortness of breath | |

Skin:

- | | | |
|--|--------------------------------|--------------------------------------|
| <input type="checkbox"/> changes hair or nails | <input type="checkbox"/> lumps | <input type="checkbox"/> thick scars |
| <input type="checkbox"/> dry, scaly skin | <input type="checkbox"/> rash | |
| <input type="checkbox"/> itching | <input type="checkbox"/> sores | |

Urinary

- | | | |
|---|--|---|
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> difficulties with urination | <input type="checkbox"/> urinary incontinence |
| <input type="checkbox"/> burning with urination | <input type="checkbox"/> flank pain | <input type="checkbox"/> urinary urgency |
| <input type="checkbox"/> decrease force-stream | <input type="checkbox"/> lack of urination | |
| <input type="checkbox"/> dialysis | <input type="checkbox"/> urinate frequent @ night | |

Vascular:

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> cold feet | <input type="checkbox"/> pain in calves at rest | <input type="checkbox"/> thrombophlebitis |
| <input type="checkbox"/> leg cramps | <input type="checkbox"/> pain-calves w/exercise | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> leg swelling | <input type="checkbox"/> pain-calves w/walking | |