IVANREST FOOT & ANKLE SPECIALIST
3050 Ivanrest Ave. SW, Suite E
Grandville, MI 49418
616.406.0102

GENERAL INFORMATION

First Name: _____ Middle: _____ Last Name: _____

What specific problem brings you to our office today? _____

_____

Where is the pain/problem located? _____

Describe the type of pain you are experiencing (mark all that apply):

☐ Aching Pain ☐ Itching ☐ Shooting Pain ☐ Tingling
☐ Burning Pain ☐ Numbness ☐ Tenderness ☐ Other _____
☐ Dull Pain ☐ Sharp Pain ☐ Throbbing Pain _____

When did your symptoms start? _____

Did they start: ☐ Gradually Over Time ☐ Sudden Onset

What makes your pain or problem better?

☐ Walking and/or Running ☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoe
☐ Resting ☐ Standing ☐ Daily Activities ☐ Ice
Daily Activities
☐ Stretching ☐ Other _____

What makes your symptoms worse?

☐ Rest ☐ At the end of the day ☐ Throughout the day ☐ During Activity
☐ Stretching ☐ Shoe gear ☐ Ice ☐ After Activity
☐ Other _____

When are your symptoms most bothersome?

☐ First thing in a.m. ☐ At end of day ☐ Throughout the day ☐ During Activity
☐ After Activity

Have you had any previous treatment or have you tried any home remedies for this problem? _____

_____

_____

How would you rate your pain on a scale from 0 to 10?

[no pain] 0 1 2 3 4 5 6 7 8 9 10 [worst pain possible]

Please List physical activities in which you are involved: _____

_____

_____

What is your Shoe Size? _____ Height: _____ Weight: _____

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MEDICAL INFORMATION

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Do you have Diabetes? ☐ Yes ☐ No Number of years _____ If yes, do you take insulin? ☐ Yes ☐ No

List serious illnesses: _____

List previous surgeries: _____

Primary Care Physician: _____ Date you last saw this Doctor: _____

Are you allergic to any medication or substances? ☐ Yes ☐ No If yes, please list: _____

List the medications & dosages you take regularly including vitamins or suppliments: _____

Are you or could you be pregnant? ☐ Yes ☐ No

Review of Systems:

Please indicate any symptoms you have experienced in the last 12 months:

CARDIOVASCULAR:	MUSCULOSKELETAL :	PERIPHERAL VASCULAR :	NEUROLOGIC :
☐ Chest Pain	☐ Joint Stiffness	☐ Swollen Legs	☐ Numbness
☐ Shortness of Breath	☐ Foot Deformity	☐ Temperature Changes of Feet	☐ Tingling
	☐ Joint Aches/Pains	☐ Easy Bruising	☐ Burning
	☐ Lower Extremity Weakness		☐ Frequent Stumbling/Falling
			☐ Dizziness

Past Medical History:

Have you ever been treated or been informed by a physician that you have had any problems with the following?

☐ Anemia	☐ Circulatory Problems	☐ HIV / AIDS	☐ Sleep Apnea
☐ Arthritis	☐ Diabetes	☐ Intestinal Problems	☐ Stomach Ulcers
☐ Asthma	☐ Drug Abuse	☐ Kidney Disease	☐ Stroke
☐ Bleeding Disorder	☐ Gout	☐ Liver Disease	☐ Tuberculosis
☐ Blood Clots	☐ Healing Problems	☐ Lung Disease	
☐ Blood Pressure Problems	☐ Heart	☐ Neurological Disorder	
☐ Cancer	☐ Hepatitis	☐ Sickle Cell Disease	

Do you have any surgically placed prosthesis? (heart valve, hip joint, etc.) ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs per day: _____ How long? _____

Have you smoked previously? ☐ Yes ☐ No Number of years: _____

Use of Recreational Drugs: ☐ Never ☐ Quit - How long ago? _____ Type _____

☐ Current Use - Type _____ Rare Occasional Moderate Daily

Do you drink alcohol or beer? ☐ Yes ☐ No ☐ Light usage (1-2 weekly) ☐ Moderate usage (1-2 daily) ☐ Heavy usage (2+ daily)

Employment ☐ Sit at Job ☐ Stand at Job ☐ Stand & Walk at Job ☐ Retired

FAMILY HISTORY

Is there a family history of:	Living	Deceased	Bleeding Disorder	Blood Clots	Cancer	Diabetes	Heart Disease	Hypertension	Unknown	No known
Dad										
Mom										
Brother										
Sister										

SIGNATURE: _____ DATE: _____