PHOENIX FOOT AND ANKLE INSTITUTE

## Established Patient Questionnaire

### Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____

**1. Any changes in past medical history?** **[ ] YES** **[ ] NO**

If yes, please explain. _____

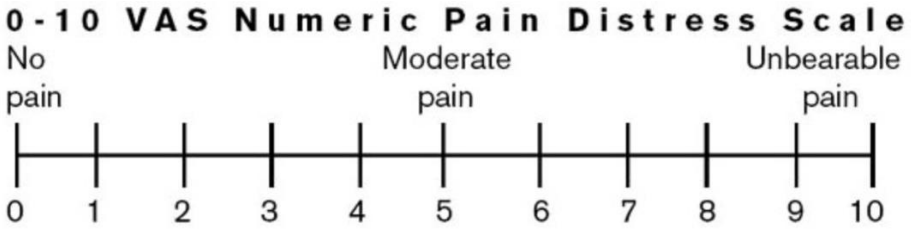
**2. Any changes in medications?** **[ ] YES** **[ ] NO**

If yes, please list any changes in medications. _____

**3. Any changes in allergies?** **[ ] YES** **[ ] NO**

If yes, please list any new allergies. _____

**4. Rate your pain as:** **[ ] improving** **[ ] unchanged** **[ ] worsening**




### Review of Systems

**General:** [ ] Loss of appetite [ ] Recent weight loss/ gain [ ] Fatigue [ ] Fever or chills [ ] Weakness
**Respiratory:** [ ] Shortness of breath [ ] Cough [ ] Coughing blood [ ] Difficulty breathing [ ] Wheezing
**Cardiovascular:** [ ] Chest pain [ ] Tightness [ ] Palpitations [ ] Swelling [ ] Difficulty breathing lying
**Head/ Eyes/ Ears/ Nose/ Throat:** [ ] Headache [ ] Neck Pain [ ]Decreased Hearing [ ]Ringing in ears [ ]Vision changes [ ]Cataracts [ ]Blurry/ double vision [ ] Itching nose [ ]Sinus pain [ ]Nosebleeds
**Neurological:** [ ] Dizziness [ ] Fainting [ ] Seizures [ ] Numbness [ ] Tingling
**Gastrointestinal:** [ ] Nausea [ ] Vomiting [ ]Constipation [ ]Diarrhea [ ]Heartburn
**Endocrine:** [ ]Sweating [ ] Frequent Urination [ ] Excessive thirst [ ] Change in appetite
**Psychiatric:** [ ] Nervousness [ ] Stress [ ] Depression [ ] Memory loss
**Skin:** [ ] Rashes [ ] Itching [ ] Dryness [ ]Hair or Nail Changes [ ] Skin color changes
**Kidney/ Bladder/ Urine:** [ ] Frequency [ ] Urgency [ ]Burning or pain [ ]Blood in urine [ ] Incontinence
**Musculoskeletal:** [ ] Muscle or joint pain [ ] stiffness [ ] back pain [ ]swelling of joints

_____ _____

**Signature of patient or patient's parent/ legal guardian** **Date**