ARYA FOOT & ANKLE

ESTABLISHED PATIENT

Established Patient Questionnaire

Legal Name: _____
First Name MI Last 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 medication: _____

3. Any changes in allergies? ❑ Yes ❑ No
   If yes, please list any new allergies: _____

4. Rate your pain as:
   ❑ Improving ❑ Unchanged ❑ Worsening

Pain Scale

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6	7	8	9	10

(No Pain) (Worst Pain)

Review of Symptoms – *Mark "None" for each condition that does not apply.*

Heart
❑ Chest Pain
❑ High Blood Pressure
❑ Swelling in Legs
❑ **None**

Psychiatric
❑ Anxiety
❑ Depression
❑ Mood Swings
❑ **None**

Skin
❑ Non-healing wound
❑ Nail Appearance Change
❑ Wart
❑ **None**

Neurological
❑ Migraines
❑ Numbness
❑ Paralysis
❑ **None**

Endocrine
❑ Diabetes
❑ Excessive Urination
❑ Increased Thirst
❑ Thyroid Trouble
❑ **None**

Hematological
❑ Anemia
❑ Bleeding Easily
❑ Blood Transfusions
❑ Easy Bruising
❑ **None**

Immunological
❑ Allergies
❑ HIV
❑ Recurrent Infections
❑ Seasonal Allergies
❑ **None**

Urinary/Reproductive
❑ Blood Urine
❑ Pregnant
❑ Urinary Incontinence
❑ **None**

Patient or Legal Authorized Representative:

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

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CLEAR FORM