FLORIDA FOOT ANKLE ASSOCIATES

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Fellow, American college of Foot and Ankle Surgeons

Patient Questionnaire

Name:____
Date:____________________________ Date of Birth:________________________

Please check any of the following conditions you are currently experiencing or suffering from:

__Flatt feet
__Heel or arch pain
__Achilles tendon pain
__Ankle swelling or stiffness
__Burning of the foot/toes/legs
__Pain or fatigue of feet or legs with activity
__Pain with brisk walking or running
__Coldness in the legs or feet that is uncomfortable
__Non/slow healing sore on the foot or
__Poor coordination
__Leg pain (shin splints)
__Discoloration of toes/foot
__Pain in the feet or legs with exercise
__Pain in the feet getting out of bed
__Ankle instability
__Leg pain at the same distance every time
__Feet or toes feel numb

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No
Is this condition causing or are you suffering with any of the following:

Tingling/numbness in:
__Legs R / L
__Ankle R / L
__Feet R / L
__Bending
__Lifting
__Kneeling

Pain radiating into:
__Ankle R / L
__Feet R / L
__Toes R / L

Weakness of the:
__Legs R / L
__Ankle R / L
__Toes R / L

Difficulty with:
__Standing
__Walking
__Sitting

How long have you been suffering with this condition? Days / Weeks / Months / longer
Is this condition affecting your ability to perform daily tasks? Yes / No
Would you like to get rid of or reduce this problem? Yes / No

There may be treatment options or solutions for the pain that you are experiencing. Please let us know what you would like to do today:

- I would like to discuss the above condition with the doctor so that I can make an educated decision about my health.
- If it were available, I would be interested in receiving treatment for this condition in this office.
- If available, I would be open to have a medical test to further evaluate my problem.

Patient signature:____

Notice of privacy practices acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protect health information. I understand that this information can and will be used to

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name____

Relationship to Patient____

Signature____

Date ____

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