MINNEAPOLIS ORTHOPAEDICS

Advanced skills and experience for the results you deserve

PATIENT INFORMATION SHEET

Foot/Ankle Right or Left

Name: _____

Date:_____

Please give a brief description of your symptoms/problems. (Where and how does it hurt)

_____

_____

When did this start?
(approximate date or number of days, weeks, months, years)

_____

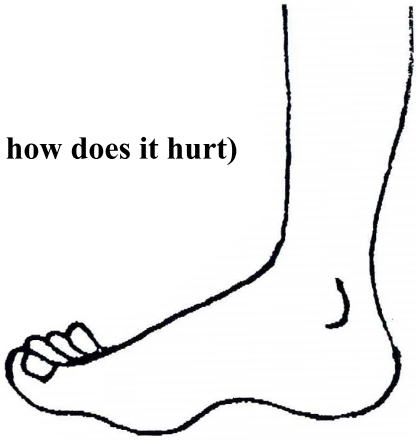
How did this happen? Were you injured?

_____

Where is your problem?
(please circle or color in area on pictures to the right)

Is there? (circle words that apply and describe)
Pain/swelling/discoloring/open wound/weakness/tingling/numbness

Draw in area of problem on diagram.
Side of foot or top of foot (circle which side picture/diagram represents).



Side of Foot

Top of Foot

Have you had any surgery or treatment in this area?

If so, when? _____

If you know – describe surgery _____

Have you had any of the following exams done previously in this area?

X-ray	Where?_____	When?_____
Bone Scan	Where?_____	When?_____
CT Scan	Where?_____	When?_____
Magnetic Resonance Imaging (MRI)	Where?_____	When?_____