Ankle and Foot Associates PLLC
REVIEW OF SYSTEMS

PLEASE fill in bubble - Mark YES only if the problem or symptom is CURRENT - Otherwise mark NO

FOOT / ANKLE

Pain	O YES	O NO
Swelling	O YES	O NO
Crooked Toe	O YES	O NO
Toenail Problem	O YES	O NO
Circulation Problem	O YES	O NO
Burning	O YES	O NO
Numbness	O YES	O NO
Skin Problem	O YES	O NO

MUSCULOSKELETAL

Joint Stiffness	O YES	O NO
Joint Pain	O YES	O NO
Joint Swelling	O YES	O NO
Joint Redness	O YES	O NO
Back Pain	O YES	O NO
Muscle Weakness	O YES	O NO

DERMATOLOGY

Rash	O YES	O NO
Itching	O YES	O NO
Callus	O YES	O NO
Deformed Nails	O YES	O NO
Change in Mole	O YES	O NO
Wound	O YES	O NO
Infection	O YES	O NO

GENERAL

Fever	O YES	O NO
Weakness	O YES	O NO
Night Sweats	O YES	O NO
Change in Energy	O YES	O NO

NEUROLOGY

Tingling/Numbness	O YES	O NO
Balance Problems	O YES	O NO

GASTROENTERLOGY

Nausea	O YES	O NO
Vomiting	O YES	O NO

ENDOCRINOLOGY

Cold Intolerance	O YES	O NO
Heat Intolerance	O YES	O NO

CARDIOLOGY / RESPIRATORY

Shortness of Breath	O YES	O NO
Vein Problems	O YES	O NO

PSYCHOLOGY

Depression	O YES	O NO
High Stress Level	O YES	O NO

Please list all Medications/Vitamins you are currently taking:

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Please list all Medications/Vitamins you are allergic to:

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Please list any SURGERIES, MAJOR PROCEDURES, HOSPITALIZATIONS or INJURIES:

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Anything not listed that you feel the Provider should know:

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Whom may we thank for referring you?

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