HMC HAND/FOOT AND ANKLE INSTITUTE QUESTIONNAIRE

HISTORY OF PRESENT ILLNESS
1. What are we seeing you for today? ___________________________________________
2. What is the goal of your visit? ____________________________________________
3. Where is the problem located? ____________________________________________
4. When and how did this injury begin? _______________________________________
5. What treatments have you had for this condition?
   ☐ Physical Therapy ☐ Bracing/Orthotics
   □ Injections ☐ Surgery (where and surgeon name): ___________________________
6. Any swelling, change in size, shape, numbness, catching or weakness? _______

7. What studies have you had for this problem?
   ☐ X-rays ☐ CT ☐ MRI
   □ Nerve Study (EMG) ☐ Arthrogram ☐ Bone Scan

PAST SURGICAL HISTORY (list all)
_____________________________________________________
_____________________________________________________________________________________

PAIN
8. Do you have pain that has been present for 3 months or longer? □ No □ Yes
9. Do you use a pain pump or stimulator? □ No □ Yes

10. Rate your pain on average in the last week on a scale of 0 (no pain) – 10 (worst possible pain) ______

11. Circle the number that describes how, during the past week, pain has interfered with your
    a. General activity (0 not at all) 1 2 3 4 5 6 7 8 9 10 (extremely)
    b. Enjoyment of life (0 not at all) 1 2 3 4 5 6 7 8 9 10 (extremely)

12. Where is the pain on your body? ____________________________________________

13. Describe your pain (Sharp, dull, etc.): ______________________________________

14. What makes your pain or problem better? _____________________________________

15. What makes your pain or problem worse? _____________________________________
16. What makes your pain or problem change? Is it associated with anything else? ________________

17. What provider is managing your pain? ____________________________________________________________________

ACTIVITY HISTORY

18. Are you currently working: ☐ No ☐ Yes, Occupation: ____________________________________________________________________

19. Is this a work related injury? ☐ No ☐ Yes, LWCP: ____________________________________________________________________

20. If disabled, what is the date that you last worked? ____________________________________________________________________

SIGNATURE  PRINT NAME  PAGER  NPI  DATE  TIME