

Jacob D. Rozbruch, M.D.

ORTHOPAEDIC SURGERY

FOOT/ANKLE NEW PATIENT FORM

Name: _____ DOB: _____ Date: _____

Chart # _____ Age: _____ BP: _____ HR: _____ Resp: _____ Temp: _____

Occupation: _____ Employer: _____

Referring Physician: _____

Primary Care Physician: _____

Chief Complaint: Right Left Date of Injury: _____

Where is your greatest area of pain?: _____

Are your problems (check one): Mild Moderate Severe

Do you require the use of a (check all that apply): Cane Crutches Walker Wheelchair

Aggravating factors: _____

Alleviating factors: _____

Have you received any of the following treatments (please circle)? If yes, please describe.

Medication? Yes No _____

Shoewear Changes? Yes No _____

Pads? Yes No _____

Arch Supports? Yes No _____

Custom Orthotics? Yes No _____

Physical Therapy? Yes No # of sessions: _____

Braces? Yes No Yes No _____

Walking Boots? Yes No _____

Casting? Yes No _____

Surgery? Yes No _____

Please list any activities that you enjoy (sports or leisure): _____

Has this condition limited your ability to pursue these activities?: _____

Notes: _____
