# Jacob D. Rozbruch, MD
## Orthopaedic Surgery

## FOOT/ANKLE NEW PATIENT FORM

Name: _____ DOB: _____ Date: _____

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

Occupation: _____ Empolyer: _____

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: _____

_____