Foot and Ankle Service
PATIENT REGISTRATION FORM

MRN#: *Office Use*

Date:

Patient First Name: **M.I.:** **Last Name:**

Physician:

Dr. Bohne Dr. Deland Dr. Elliott Dr. Ellis Dr. Kennedy Dr. Levine Dr. O'Malley Dr. Roberts

Please complete this form in its entirety. If you have previously completed this form, fill in your name, today's date, provide us with any changes that have occurred since your last visit and sign the last page of this form.

Type of Visit: Initial Visit Follow Up Pre-Op Visit Post-Op Study Patient

Street Address

City: State: Zip: Country:

Temporary Address in the US: Birthplace:

Home Phone:

Day Phone:

Cell Phone:

Email:

Date of Birth:

Age:

Gender: Male Female

Emergency Contact Information:

Name and relationship:

Phone:

Guarantor Responsible for Bill:

Name and Phone:

Spouse Name and Employment Information:

Name:

Employer:

Race (optional): White Black Hispanic Origin Asian Other

Occupation: Employer/Address:

Full Time Part Time Self Employed Between Jobs Retired

Marital Status: Single Divorced Married Separated Widowed Unknown

Do you live alone?: Yes No If No, how many people do you live with?: 1 2 3 More

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Primary Insurance: Group/ Policy #: Secondary Insurance: Group/ Policy #:

Address: Address:

Insured's Name: Insured's Name:

Insured's Date of Birth: Insured's Date of Birth:

Relation to Patient: Relation to Patient:

WCB Case #: Claim #: No Fault #:

Carrier: Address: Contact:

Primary Care Physician:

Referred by:

Orthotics:

Yes No

Physician Address and Phone:

Referred Address and Phone:

Prior Surgery and Date (please list them):

1.

2.

3.

Complications from Prior Surgery:

Yes No

If Yes, please explain:

Have you ever had general anesthesia?:

Yes No

Have you ever had any problems with anesthesia?:

Yes No

Reason for Today's Visit:

Duration Symptoms: Less than 1 month 1-6 months 1-3 years 5 years or more

Site: Right Left Both

Location of Pain: Foot Ankle Both Toe(s) Other

Have you been treated for this problem before?: Yes No If yes, when? Where?

Previous patient at Hospital for Special Surgery?: Yes No If yes: Foot Ankle Other (Specify):

Name and address of physician(s):

Accident / Injury?: Yes No Date of Injury: Receiving worker's compensation: Yes No

Type: Vehicle: Yes No Employment: Yes No Other Explain:

Do you smoke?: Yes No If yes, how long? (years)

Do you drink alcohol?: Yes No If yes: Daily Weekly Monthly

Are you a vegetarian?: Yes No

Are you on Hormone Replacement Therapy?: Yes No

Athletic and Physical Activities:

- Biking
- Walking
- Runnng
- Football
- Tennis
- Basketball
- Soccer
- Hockey
- Lacrosse
- Swimming
- Weight Lifting
- Golf
- Squash
- Dancing/Aerobics

Level of Play: Professional College High School Recreational

Please check any illnesses you have or had:

- ☐ Bleeding tendency
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Chronic Pulmonary Disease
- ☐ COPD
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Diabetes
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Blood in urine
- ☐ Bladder infections
- ☐ Difficulty controlling urine
- ☐ Glaucoma
- ☐ Lupus erythematosis
- ☐ Fatigue
- ☐ Seizures
- ☐ Dizziness/fainting
- ☐ Headache
- ☐ Stroke/TIA
- ☐ Weakness
- ☐ Numbness
- ☐ Cancer
- ☐ Sleep apnea
- ☐ Thyroid disease
- ☐ Depression
- ☐ Anxiety
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Sciatica
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Anemia
- ☐ Shingles
- ☐ Blood clot
- ☐ Venereal disease
- ☐ Hepatitis
- ☐ Other

Specify: _____

List current medication(s):	Dosage:
1.	
2.	
3.	

Allergies: ◯ Yes (please list below) ◯ No

1. _____
2. _____
3. _____

Assignment and Release of Information statement : I certify that the information provided by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital-affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign benefits to the physician and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.
Medicare patients : I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles and co-insurance payments on all services. When Medicare is deemed the secondary insurance, I will follow payment terms.

Patient/Guardian Name: _____ Signature: _____ Date: _____

Foot and Ankle Service

FOOT AND ANKLE SURVEY

MRN#: *Office Use*

Date:

Patient First Name: M.I.: Last Name:

Physician:

☐ Dr. Bohne ☐ Dr. Deland ☐ Dr. Elliott ☐ Dr. Ellis ☐ Dr. Kennedy ☐ Dr. Levine ☐ Dr. O'Malley ☐ Dr. Roberts

INSTRUCTIONS: This survey asks for your view about your level of activity. This information will help us keep track of how your symptoms interfere with your functioning. Please answer every question by filling in the appropriate circle, only one selection for each question. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms

These questions should be answered thinking of your foot/ankle symptoms during the last week.

	Never	Rarely	Sometimes	Often	Always
SI. Do you have swelling in your foot/ankle?	○	○	○	○	○
S2. Do you feel grinding, hear clicking or any other type of noise when your foot/ankle moves?	○	○	○	○	○
S3. Does your foot/ankle catch or hang up when moving?	○	○	○	○	○

	Always	Often	Sometimes	Rarely	Never
S4. Can you straighten your foot/ankle fully?	○	○	○	○	○
S5. Can you bend your foot/ankle fully?	○	○	○	○	○

Stiffness

The following questions concern the amount of joint stiffness you have experienced during the last week in your foot/ankle. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.

	None	Mild	Moderate	Severe	Extreme
S6. How severe is your foot/ankle stiffness after first wakening in the morning?	○	○	○	○	○
S7. How severe is your foot/ankle stiffness after sitting, laying or resting **later in the day?**	○	○	○	○	○

Pain

	Never	Monthly	Weekly	Daily	Always
P1. How often do you experience foot/ankle pain?	○	○	○	○	○

What amount of foot/ankle pain have you experienced the last week during the following activities?

	None	Mild	Moderate	Severe	Extreme
P2. Twisting/pivoting on your foot/ankle	◯	◯	◯	◯	◯
P3. Straightening foot/ankle fully	◯	◯	◯	◯	◯
P4. Bending foot/ankle fully	◯	◯	◯	◯	◯
P5. Walking on flat surface	◯	◯	◯	◯	◯
P6. Going up or down stairs	◯	◯	◯	◯	◯
P7. At night while in bed	◯	◯	◯	◯	◯
P8. Sitting or laying	◯	◯	◯	◯	◯
P9. Standing upright	◯	◯	◯	◯	◯

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the last week due to your foot/ankle.

	None	Mild	Moderate	Severe	Extreme
Al. Descending stairs	◯	◯	◯	◯	◯
A2. Ascending stairs	◯	◯	◯	◯	◯
A3. Rising from sitting	◯	◯	◯	◯	◯
A4. Standing	◯	◯	◯	◯	◯
A5. Bending to floor/pick up an object	◯	◯	◯	◯	◯
A6. Walking on flat surface	◯	◯	◯	◯	◯
A7. Getting in/out of car	◯	◯	◯	◯	◯
A8. Going shopping	◯	◯	◯	◯	◯
A9. Putting on socks/stockings	◯	◯	◯	◯	◯
A10. Rising from bed	◯	◯	◯	◯	◯

For each of the following activities please indicate the degree of difficulty you have experienced in the last week due to your foot/ankle.

	None	Mild	Moderate	Severe	Extreme
A11. Taking off socks/stockings	◯	◯	◯	◯	◯
A12. Laying in bed (Turning over, maintaining knee position)	◯	◯	◯	◯	◯
A13. Getting in/out of bath	◯	◯	◯	◯	◯
A14. Sitting	◯	◯	◯	◯	◯
A15. Getting on/off toilet	◯	◯	◯	◯	◯
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)	◯	◯	◯	◯	◯
A17. Light domestic duties (cooking, dusting, etc)	◯	◯	◯	◯	◯

Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the last week due to your foot/ankle.

	None	Mild	Moderate	Severe	Extreme
SP1. Squatting	◯	◯	◯	◯	◯
SP2. Running	◯	◯	◯	◯	◯
SP3. Jumping	◯	◯	◯	◯	◯
SP4. Twisting/pivoting on your injured foot/ankle	◯	◯	◯	◯	◯
SP5. Kneeling	◯	◯	◯	◯	◯

Quality of Life

Q1. How often are you aware of your foot/ankle problem?

◯ Never ◯ Monthly ◯ Weekly ◯ Daily ◯ Constantly

Q2. Have you modified your life style to avoid potentially damaging activities to your foot/ankle?

◯ Not at all ◯ Mildly ◯ Moderately ◯ Severely ◯ Totally

Q3. How much are you troubled with lack of confidence in your foot/ankle?

◯ Not at all ◯ Mildly ◯ Moderately ◯ Severely ◯ Extremely

Q4. In general, how much difficulty do you have with your foot/ankle?

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme

Foot and Ankle Service

GENERAL HEALTH SURVEY / SF-12v2

MRN#: *Office Use*

Date:

Patient First Name: M.I.: Last Name:

Physician:

☐ Dr. Bohne ☐ Dr. Deland ☐ Dr. Elliott ☐ Dr. Ellis ☐ Dr. Kennedy ☐ Dr. Levine ☐ Dr. O'Malley ☐ Dr. Roberts

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!

Please answer these questions taking into account all medical conditions you may have, including your foot & ankle problem. Please fill in only one response that best describes your answer.

1. In general, would you say your health is:

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please fell ONLY ONE CIRCLE)

	Limited a Lot	Limited a Little	Not Limited at All
a. First, moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
b. Climbing several flights of stairs	○	○	○

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	○	○	○	○	○
b. Were limited in the kind of work or other activities	○	○	○	○	○

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	○	○	○	○	○
b. Did work or other activities less carefully than usual	○	○	○	○	○

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	◯	◯	◯	◯	◯
b. Did you have a lot of energy?	◯	◯	◯	◯	◯
c. Have you felt downhearted and depressed?	◯	◯	◯	◯	◯

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All the time	Most of the time	Some of the time	A little of the time	None of the time
◯	◯	◯	◯	◯

8 . On a scale of 0 – 10, 10 being the worst pain and 0 being no pain, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Foot and Ankle Service
ACTIVITY RATING SCALE

MRN#: *Office Use*

Date:

Patient First Name: **M.I.:** **Last Name:**

Physician:

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Activities

Please, indicate how often you performed each activity in your healthiest and most active state, **during the past year.**

	Less than one time in a month	One time in a month	One time in a week	2 or 3 times in a week	4 or more times in a week
A1. Running Running while playing a sport or jogging	○	○	○	○	○
A2. Cutting Changing directions while running	○	○	○	○	○
A3. Decelerating Coming to a quick stop while running	○	○	○	○	○
A4. Pivoting Turning your body with your foot planted For example: skiing, skating, kicking, throwing, hitting a ball (golf, squash, tennis), etc	○	○	○	○	○

Print Form

Please print this form and bring it to your appointment.

☐ I wish to submit this form by email. I understand and accept that (1) the Internet is an open network that provides no inherent protection for confidential information, and (2) submitting this form by email poses risks to the confidentiality of my health information. I also understand that I am not required to submit this form by email; I can instead print it and bring it to my first visit.

Submit Form via Email

Clicking this submit button should bring up an email window with your data file attached. Please send this email.
If you don't see an email window, you may also save this file to your desktop and attach it to an web-based email and send it to one of the physician's addresses on the right:

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