CBJD

THE CENTER FOR BONE & JOINT DISEASE

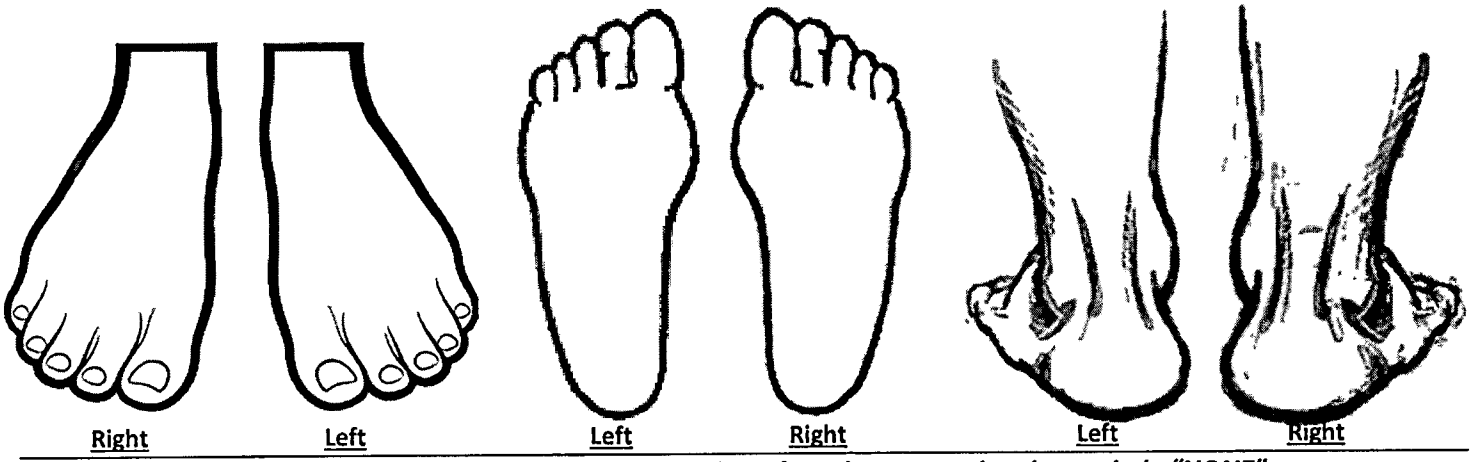
Patient Name: _____

Date: _____

Dr. Alexander Pappas D.P.M, FACFAS New Patient Pain Drawing

Please use the diagrams below to pin point where your pain is located:

Top of Feet **Bottom of Feet** **Back of feet**



Right **Left** **Left** **Right** **Left** **Right**

Please circle the type of pain you are having. If you have no pain, please circle "NONE".

Sharp electric dull & aching shooting burning

throbbing cramping numbness tingling

NONE

Please circle your AVERAGE pain level below. With "0" being no pain and "10" being the worst pain.

0 1 2 3 4 5 6 7 8 9 10

Have you ever had any treatment for your feet or ankles? (Treatment by another doctor, over-the-counter braces/shoe inserts, etc.) If YES, please list them below, including the date and the doctor's name if known.

_____

_____

Shoe size: _____

Shoe width: Narrow Medium Wide Extra Wide

Do you have a Primary Care Doctor? Name (if any): _____

Are you a current smoker? Yes or No ----------

If *YES*, how long have you been smoking for? _____ **How much do you smoke a day?** _____

Have you previously smoked cigarettes? Yes or No

If *YES*, how long did you smoke for? _____ **How much did you smoke a day?** _____

What year did you quit smoking? _____

Are you diabetic? Yes or No ----- **Type:** 1 or 2

If ***YES***, please answer the questions below.

Are you insulin dependent? Yes or No

When was your last blood sugar check? (date) _____ **What were the results?** _____

When was your last A1C blood test? (date) _____ **What were the results?** _____