DR. REESE'S QUESTIONNAIRE
South Bay Orthopaedic Specialists

PATIENT'S NAME:
TODAY'S DATE:

(Circle) RIGHT LEFT

How long has your _____ been bothering you?_____(time)

Describe your symptoms (Check all that apply)

Pain: Rate your discomfort (circle) None 1 2 3 4 5 6 7 8 9 10

Location: (circle)

Big Toe	Lesser Toes	Arch
Heel	Back of Heel	Ankle
Ball of foot	Other: _____	

Quality and duration of pain:

Sharp	Dull	Burning
Throbbing	Constant	Tingling
Intermittent (on/off)		

Stiffness: Where?_____
Numbness: Where?_____
Swelling: Where?_____
Weakness: Where?_____

Difficulty walking (circle): Yes No
Do you use orthotics? Yes No

Do you use assistive devices? No Cane Walker Crutches

When do your symptoms occur (circle all that apply)?

Walking	Running	During exercise	After exercise
In morning	At night		

What makes your symptoms better (circle all that apply)?

Rest	Ice	Medication_____
Brace	Heat	Physical Therapy

Have you ever had other treatment for this? Yes No
If yes, please describe_____

This document has been reviewed by_____, M.D.

Dr. Keri Reese
South Bay Orthopaedic Specialists

DR REESE'S HEALTH FORM AND PATIENT HISTORY
South Bay Orthopaedic Specialists

Patient Name:
Today's Date:
DOB/Age:

Have you ever had a blood clot (DVT: Deep venous thrombosis) that needed medical treatment? Yes No If yes, when?_____

Do you have diabetes?	Yes	No
Do you have circulatory problems (PAD/PVD)?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have a heart problem?	Yes	No
Do you smoke?	Yes	No

Medical Problems: (please list all medical problems such as asthma, heart problems, high blood pressure, gout, migraines, restless legs, diabetes, emphysema etc…..)

1) _____
2)_____
3)_____
4)_____
5)_____

Medications: (please list any medications you take either regularly or sometimes)

Name Dose

_____
_____
_____
_____
_____

Allergies: Please list any allergies below

_____
_____

Past Surgical History: (please list all previous surgeries and approx. year)

_____
_____
_____
_____
_____

Reviewed by: ,M.D. (Page 1)

Review of systems:
Are you currently having, or have you had any problems with your:

	Circle		*Describe all yes responses*
Eyes?	Yes	No	_____
Ears, Nose, Throat?	Yes	No	_____
Lungs/Breathing?	Yes	No	_____
Digestion/Bowel Movement?	Yes	No	_____
Bladder problems?	Yes	No	_____
Diabetes?	Yes	No	_____
High Blood Pressure?	Yes	No	_____
Bleeding/Lymphatic?	Yes	No	_____
Balance problems?	Yes	No	_____
Numbness/Tingling?	Yes	No	_____
Blackout/fainting?	Yes	No	_____
Skin problems?	Yes	No	_____
Psychological problems?	Yes	No	_____
Cancer?	Yes	No	_____
Endocrine/Immunologic?	Yes	No	_____

Social History:
Do you currently work? Yes No If yes, please list occupation_____
Do you live alone? Yes No
Do you exercise? Yes No If yes, how often/what type?_____
Do you currently smoke? Yes No If yes, how much _____
Did you used to smoke? Yes No If yes, for how many years _____
Do you drink alcohol? Yes No If yes, how often _____
Do you have a history of substance abuse? Yes No If yes, what? _____

Family History:

Member	Alive / Deceased	Age	Health status or cause of death
Mother	A D		
Father	A D		
Brother/Sister	A D		
Brother/Sister	A D		
Brother/Sister	A D		
Grandmother (Dad's)	A D		
Grandfather (Dad's)	A D		
Grandmother (Mom's)	A D		
Grandfather (Mom's)	A D		

Reviewed by: ,M.D.

Dr. Keri Reese
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