

HMC HAND/FOOT AND ANKLE INSTITUTE QUESTIONNAIRE

HISTORY OF PRESENT ILLNESS

1. What are we seeing you for today? _____
 2. What is the goal of your visit? _____
 3. Where is the problem located? _____
 4. When and how did this injury begin? _____
 5. What treatments have you had for this condition? Physical Therapy Bracing/Orthotics
 Injections Surgery (*where and surgeon name*): _____
 6. Any swelling, change in size, shape, numbness, catching or weakness? _____
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7. What studies have you had for this problem? X-rays CT MRI
 Nerve Study (EMG) Arthrogram Bone Scan

PAST SURGICAL HISTORY (list all) _____

PAIN

8. Do you have pain that has been present for 3 months or longer? No Yes
9. Do you use a pain pump or stimulator? No Yes
10. Rate your pain on average in the last week on a scale of 0 (no pain) – 10 (worst possible pain) _____
11. Circle the number that describes how, during the past week, pain has interfered with your
 - a. General activity (0 not at all) 1 2 3 4 5 6 7 8 9 10 (extremely)
 - b. Enjoyment of life (0 not at all) 1 2 3 4 5 6 7 8 9 10 (extremely)
12. Where is the pain on your body? _____
13. Describe your pain (Sharp, dull, etc.): _____
14. What makes your pain or problem better? _____
15. What makes your pain or problem worse? _____

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians
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WHITE - MEDICAL RECORD

HMC2807 REV FEB 22

16. What makes your pain or problem change? Is it associated with anything else? _____

17. What provider is managing your pain? _____

ACTIVITY HISTORY

18. Are you currently working: No Yes, Occupation: _____

19. Is this a work related injury? No Yes, LWCP: _____

20. If disabled, what is the date that you last worked? _____

SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME
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