

QUESTIONNAIRE

Name: _____

| | Yes | No | Comments |
|---|--------------------------|--------------------------|----------|
| Is your general health good? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you had any serious illnesses or operations? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you had any injuries or operations on your feet or legs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have bleeding tendencies? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you or have you ever had leg cramps? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you or any family members been treated for diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Check (√) any of the following that there has been treatment for:

- Heart Problems
 Asthma
 Epilepsy
 Rheumatic Fever
 Kidney problems
 Liver Problems
 Arthritis
 Bursitis
 High Blood Pressure
 Low Blood Pressure
 Others _____

Check (√) any existing allergies: Novocaine
 Penicillin
 Adhesive Tape
 Fabric
 Others _____

Circle either "Yes" or "No" for each question. Please provide additional information where requested. Feel free to add any information you think relates to your problem.

- | | | | |
|---|--|-----|----|
| 1. Has anyone in your family ever had foot problems similar to yours? | | Yes | No |
| 2. Do you spend more than 50% of your working day standing? | | Yes | No |
| 3. How long have you had your symptoms? _____ | | | |
| 4. Are your symptoms worse after standing? | | Yes | No |
| 5. Are your symptoms worse after walking? | | Yes | No |
| 6. Are your symptoms worse after wearing shoes? | | Yes | No |
| 7. Have you tried home remedies or self treatment? | | Yes | No |
| 8. If your answer to No. 7 was yes, please describe below: | | | |

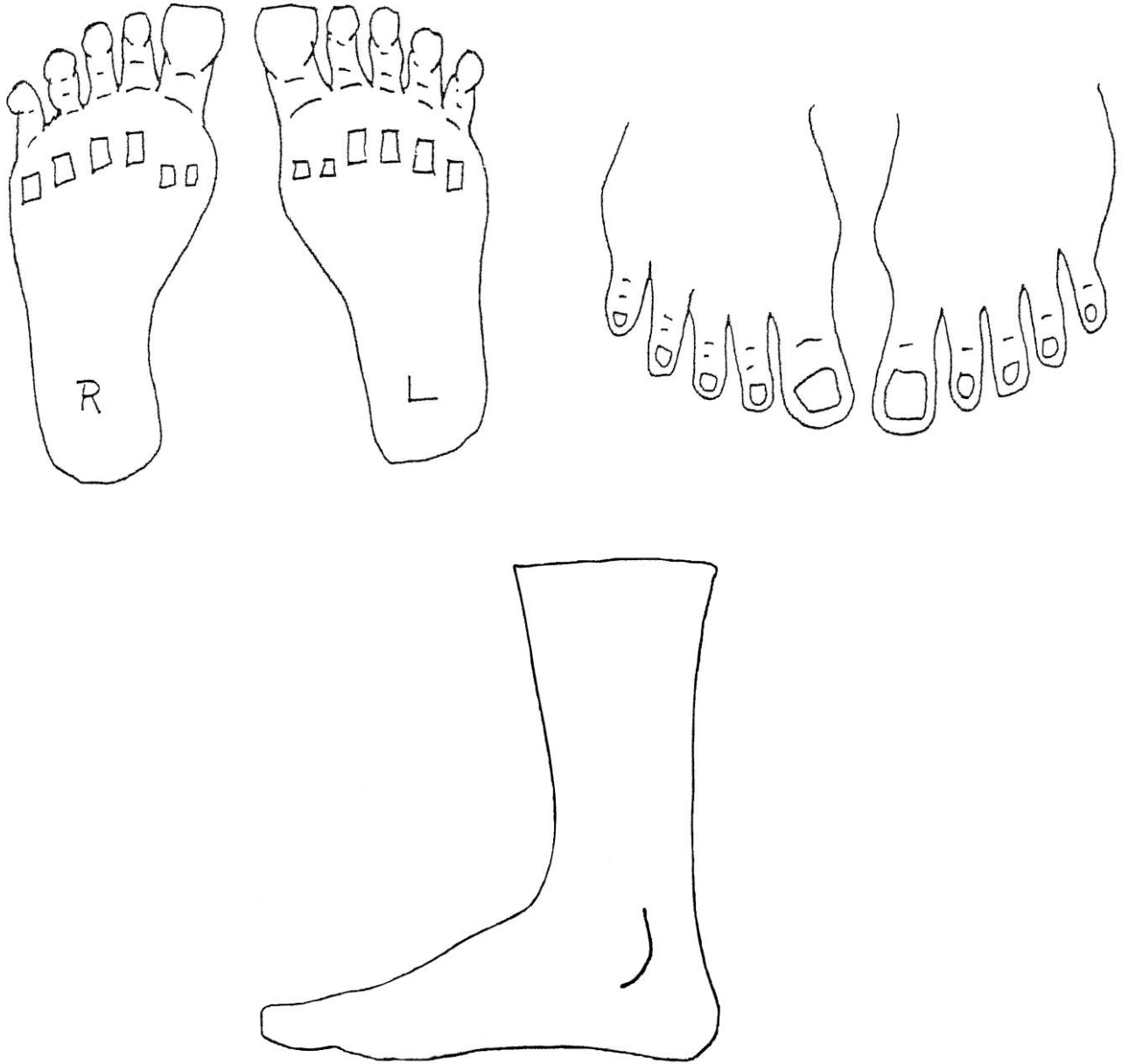
- | | | | |
|---|--|-----|----|
| 9. Have you been treated by a doctor for your foot condition? | | Yes | No |
| 10. If your answer to No. 9 was yes, please describe the treatment below: | | | |

- | | | | |
|---|--|-----|----|
| 11. Do you have pain in your feet or legs? | | Yes | No |
| 12. Do you have cramping in your feet or legs? | | Yes | No |
| 13. Do you have burning in your feet or legs? | | Yes | No |
| 14. Do you have tingling in your feet or legs? | | Yes | No |
| 15. Do you have redness/discoloration in your feet or legs? | | Yes | No |
| 16. Do you have swelling in your feet or legs? | | Yes | No |
| 17. Do you have itching in your feet? | | Yes | No |
| 18. Do you have corns? | | Yes | No |
| 19. Do you have calluses? | | Yes | No |
| 20. Does your foot problem interfere with your ability to work? | | Yes | No |
| 21. Does your foot problem interfere with your ability to carry out your normal daily activities? | | Yes | No |
| 22. List any medical conditions you have (allergies, impairments, etc.). _____ | | | |

QUESTIONNAIRE

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On the diagram below, please mark the place(s) where you are experiencing pain in your feet/ankle.



Regarding the place(s) you marked above, describe the pain you experience below.

Signature _____