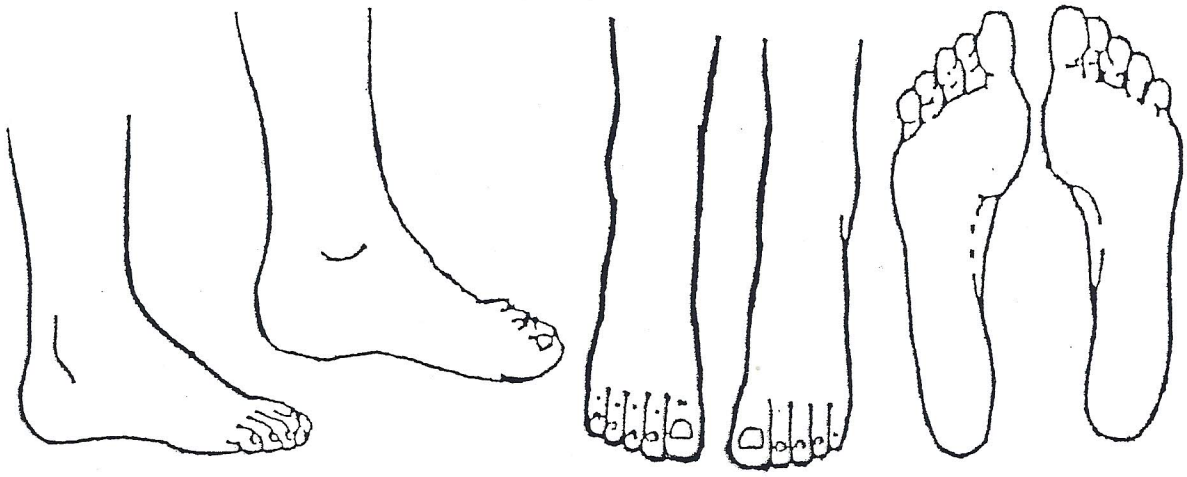
Patient # _____

Date _____

Lower Extremity



Please circle on the above drawing where you are having pain or symptoms.

Describe the sensations or symptoms you are experiencing (pain, aching, tingling, burning, numbness, etc.)

_____

Is this a result of an injury? **YES** ____ **NO** ____ If YES, give the date? _____(month-day-year)

If YES, explain how and where your injury occurred: _____

_____

Is this work related? **YES** ____**NO** ____

If this was not an injury, how long have you been experiencing your symptoms? _____

Do you feel a lump in the area of concern? **YES** or **NO** (circle) If YES, please describe how if feels to you? (hard, soft, does it move around, is it close to the surface or does it feel deep?) _____

_____

Is there a discoloration of the area? **YES** ____ **NO** ____ If YES, please describe _____

_____

Have you ever had surgery on this area before? **YES** ____ **NO** ____ If YES, when, where, and what has the surgery done for you? _____

_____

Have you ever had x-rays, a CT scan, or MRI scan for *this* problem? **YES** ____ **NO** ____ If YES, when and where, and what did they show? _____

_____

What has your doctor told you about this problem? _____

_____

Does your family have a history of cancer? **YES** ____ **NO** ____

Please give us your **HEIGHT** _____ and **WEIGHT** _____