METRO FOOT & ANKLE

PATIENT NAME: _____ D.O.B: _____/_____/_____

DESCRIBE YOUR FOOT AND ANKLE PROBLEMS:

_____

_____

PLEASE LIST ANY MEDICAL OR HEALTH PROBLEMS:

_____

_____

PLEASE LIST REGULAR MEDICATIONS AND DOSAGE:

_____

_____

PREVIOUS ANESTHETICS/SURGERIES:

_____

_____

HOSPITALIZATIONS: _____

ARE YOU CURRENTLY PREGNANT? Y / N
DO YOUR FEET GET TIRED AT THE END OF THE DAY? Y / N
DO YOU HAVE LOW BACK PAIN? Y / N

IF YOU HAVE/HAD THE FOLLOWING PLEASE CHECK (X):

___CRAMPS
___SICKLE CELL TRAIT
___HIGH BLOOD PRESSURE
___HEART PROBLEMS
___ASTHMA
___PHLEBITIS/DVT
___KIDNEY DISEASE
___HEPATITIS
___RHEUMATIC FEVER
___DIABETES
___OTHER

___GOUT
___VARICOSE VEINS
___ARTHRITIS
___ANEMIA
___STROKE
___BLOOD DISEASE
___BLEEDING PROBLEM
___LIVER TROUBLE
___AIDS/HIV
___DIGESTIVE PROB.
___OTHER

I HAVE AN ALLERGIC REACTION TO OR AM ALLERGIC TO:

___PENICILLIN ___SULFA ___ANESTHETICS (LOCAL) ___CODEINE
___ASPIRINS ___TAPE ___FOOD ___OTHER

FAMILY HISTORY: ___HYPERTENSION WHO? _____
___HEART DISEASE WHO? _____
___DIABETES WHO? _____
___FOOT PROBLEMS WHO? _____

DO YOU SMOKE? ___ AMOUNT: _____
DO YOU DRINK? ___ AMOUNT: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____ SHOE SIZE: _____