

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):

- | | |
|--|---|
| <input type="checkbox"/> CRAMPS | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> SICKLE CELL TRAIT | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> PHLEBITIS/DVT | <input type="checkbox"/> BLOOD DISEASE |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> BLEEDING PROBLEM |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> LIVER TROUBLE |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> DIGESTIVE PROB. |
| <input type="checkbox"/> OTHER | <input type="checkbox"/> 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: _____