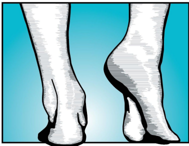


Foot & Ankle Wellness Center
Jane E. Graebner Drew J. Belpedio
Martha A. Anderson Billy J. Rutter

1871 W William Street, Delaware, OH 43015
P: 740.363.4373 | F: 740.363.9560 | www.FAAWC.com

PRE-OPERATIVE QUESTIONNAIRE

Name:____________________________ Age:_________Date Form Completed:______________

Current Address:____________________________________ State:________ Zip Code:_______

Phone: Home (___)____-______ Answering Machine Y N Best Time to Call: _____

Work (___)____-______ Extension # ___________ Best Time to Call: _____

Cell (___)____-______ E-mail Address: __________________@_____________

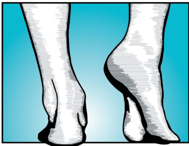
Legal guardian/parent (if under 18 years old):____

List ALL medications you are currently taking (include dosage & REASON PRESCRIBED):

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____
7) ____
8) ____
9) ____
10) ____

	Circle One Yes	No
Are you taking a blood thinner such as Aspirin, Coumadin, Warfarin, Pletal?	Y	N
Are you currently taking Plaquenil or Methotrexate?	Y	N
Can you take the following medications:		
Penicillin?	Y	N
Sulfa Antibiotics?	Y	N
Aspirin?	Y	N
Codeine?	Y	N
List all Allergies:		
Do you have any allergies to metals (such as Nickel)?	Y	N
Do you have any allergies to suture materials (such as Nylon)?	Y	N
Are you allergic or sensitive to:		
Adhesive Tape/Band-Aids?	Y	N
Iodine/Betadine?	Y	N

Local Anesthetics (i.e. Novacaine, Xylocaine)?	Y	N
Latex?	Y	N
Have you ever had a reaction of any kind from a local anesthetic injection?	Y	N
Has it ever taken more local anesthetic to produce numbness for you?	Y	N
Have you or any member of your family ever had difficulty with anesthesia of any kind (i.e. spinal, general, IV sedation, local anesthesia)?	Y	N
If yes please explain:		
Have you ever had any problems with anesthesia (i.e. general, spinal or IV sedation) such as nausea, vomiting, difficulty becoming alert?	Y	N
If yes please explain:		
Have you ever had trouble with a pain medication (i.e. sick to you stomach, headache, constipation)?	Y	N
If yes please explain:		
Do you have high pain tolerance (can you tolerate a lot of pain)?	Y	N
Do you have a low pain tolerance (cannot tolerate much pain)?	Y	N
Does a specific pain medication work well for you or member of you family?	Y	N
If yes, please list:		
List your last three (3) surgeries of any kind including the date, where performed, and the surgeon:		
1)		
2)		
3)		
Have you ever had heart by-pass surgery?	Y	N
Have you ever had surgery to improve the circulation in your legs?	Y	N
Have you ever had difficultly healing a wound?	Y	N
If yes, please explain:		
Have you ever had post-operative infection?	Y	N
Have you ever had a scar that does not look nice (i.e. enlarged, reddened)?	Y	N
Have you ever needed an antibiotic prior to dental work or surgery?	Y	N



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Do you have mitral valve prolapse?		
Do you have heart murmur?	Y	N
Do you have an artificial valve in your heart?	Y	N
Have you ever had rheumatic fever?	Y	N
Do you have sleep apnea?	Y	N
If yes: CPAP,or BIPAP? Machine settings		
Are you prone to infections?	Y	N
Have you ever had joint replacement surgery?	Y	N
Have you been anemic or had low iron in your blood?	Y	N
Have you ever had a blood clot in your leg(s)?	Y	N
Have you ever had a blood clot in your lung (pulmonary embolus)?	Y	N
Have you ever had trouble with the veins in your legs (i.e. varicose veins, phlebitis)?	Y	N
Do you have trouble with swelling in your legs?	Y	N
If yes, please explain:		
Have you ever been diagnosed with Fibromyalgia?	Y	N
Do you have trouble sleeping at night?	Y	N
Have you ever had Polio?	Y	N
Have you ever had Hepatitis?	Y	N
Have you ever had AIDS?	Y	N
Have you ever tested HIV positive?	Y	N
Have you ever worn a cast before:	Y	N
If yes, did any problems occur?	Y	N
Do you smoke cigarettes/cigars/chew tobacco?	Y	N
If yes, how many per day?		
Do you consume much caffeine?	Y	N
If yes, how much in one (1) day?		
Do you drink alcohol?	Y	N
If yes, how much in one (1) day? _______________ one (1) week? _______________		
Do you drink milk or eat dairy products?	Y	N
Do you take vitamins?	Y	N
Calcium?	Y	N
Iron?	Y	N

Question		
Have you ever used crutches?	Y	N
Have you ever used a walker?	Y	N
Do you own crutches?	Y	N
Do you own a walker?	Y	N
Do you have trouble with your knees?	Y	N
Your hips?	Y	N
Your back?	Y	N
Do you have a difference in the length of your legs?	Y	N
If yes, please explain:		
Do you usually wear an orthotic, arch support, or supportive shoes?	Y	N
What is you shoe size?		