FOOT & ANKLE
WELLNESS CENTER

Foot & Ankle Wellness Center
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Name:_____ Age:____ Wt:_____Ht: _____Today's Date:_____
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 the Medication You are Currently Taking (include dosage and reason it is prescribed):
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

	Circle One	
Are you taking a blood thinner such as Aspirin, Coumadin, Warfarin, Pletal, Fish Oil?	Y	N
(Please circle which blood thinner.)		
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
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**
Do you have mitral valve prolapse?	**Y**	**N**
Do you have an artificial valve in your heart?	**Y**	**N**
Have you ever had rheumatic fever?	**Y**	**N**
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**
Do you use C-Pap or Bi-Pap machine?	**Y**	**N**
Have you ever had Polio?	**Y**	**N**
Have you ever had Hepatitis?	**Y**	**N**
Have you ever had AIDS or tested HIV positive? (Please circle)	**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**
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?		