Patient Pre-Op Questionnaire

Regarding the foot problem that your foot/ankle surgery is addressing:

- How long have you had this problem? _____months/years
- What other treatments have been tried?

  _____

  _____
- Do you feel that conservative treatment has been exhausted? Yes No
- Is this problem affecting your daily activities? Yes No
- Are you willing to accept the risks associated with surgery to resolve Your foot/ankle problem? Yes No

  Describe the surgery you are having:

  _____

  _____

Regarding your general health and previous surgery:

- Have you ever had excessive bleeding from a cut or surgery? Yes No
- Have you ever had scarring of an incision or slow healing of a wound or cut? Yes No
- Have you ever had blood clots in the leg or lung? Yes No
- Have you ever had a bad reaction to prior surgery? Yes No

  If yes:

Prior Surgeries	Date	Type of Anesthesia
1.		
2.		
3.		

- Current Medical Conditions _____

  _____
- Family Dr. or Internist _____
- Date of Last physical _____ Last EKG _____ Last Blood Tests_____
- Have you had any Aspirin type meds in the last two weeks? Yes No
- Have you had any water pills (diuretics) or steroid pills (prednisone) Or blood thinner (Coumadin) in the last year? Yes No
- Are you allergic to any medications? Yes No

  If yes:

Medication	Type of Reaction
1.	
2.	

- Have you had a recent bladder infection or upper respiratory infection (sinusitis or bronchitis?) Yes No
- Could you possibly be pregnant? Yes No

- ❖ Have you ever smoked? Yes No
  If yes, how much? _____packs per day, for _____years
- ❖ Have you ever had: diabetes, rheumatoid arthritis, heart disease or vascular disease (blood vessel problems)? Yes No

<u>Regarding your post operative rehabilitation:</u>

- ❖ How long are you expecting to be on your back with your foot up? _____days
- ❖ How long are you expecting to be on crutches? _____weeks
- ❖ How long are you expecting to be in a cast? _____weeks
- ❖ How long are you taking off work? _____days/weeks
- ❖ Do you have someone to help you for the first few days? Yes No
- ❖ How long until you expect to get back into loose fitting shoes? _____weeks
- ❖ How long until you expect to get into dress hoes? _____months
- ❖ Are you familiar with the use of crutches? Yes No
- ❖ Do you have any fears or reservations regarding the upcoming surgery? Yes No
- ❖ Do you feel a second opinion would be helpful prior to surgery? Yes No
- ❖ Please list any preferences you have regarding anesthesia None See below

_____

_____

Patient Signature _____Date_____

Thank you for taking the time to fill out this questionnaire. This will help to assure your expectations are in line with the probably outcome of the surgery and alert us regarding any health risks you may have.

Your comments or questions:

_____

_____

_____

_____