CHO FOOT AND ANKLE SPECIALISTS

1232 Perimeter Parkway Suite 102
Virginia Beach, VA 23454

1. General information: Name ______________________________ Age _______ Height _________ Weight _________
2. Please list any allergies to food, drugs or latex: ____

____

3. Please list all medications you are currently taking, or have recently taken. Include the dose and frequency (once a day, etc.). Be sure to include aspirin, blood thinners, cortisone, and over-the counter drugs.

Medications or Herbals	Dose	Frequency
_____________________	______________	__________________
_____________________	______________	__________________
_____________________	______________	__________________
_____________________	______________	__________________
_____________________	______________	__________________
_____________________	______________	__________________

4. Please list any previous surgeries, including year, type of anesthesia and if any reactions occurred. Please include any childbirth.

Previous surgery	Year	Anesthesia type	Reaction
_____________________	_________	______________	______________
_____________________	_________	______________	______________
_____________________	_________	______________	______________
_____________________	_________	______________	______________

5. Do you have a history of any of the following: Circle "yes" or "no". If "yes", please comment.

Yes No Stroke, Seizures, Migraines, motion sickness? ____
Yes No High blood pressure, heart attack or failure, murmur, chest pain, heart surgery or heart procedures, irregular heart beat, rheumatic fever? ____
Yes No Prolapsed mitral valve? Take antibiotics for dental procedures?
Yes No Asthma, Emphysema, wheezing, chronic bronchitis, TB or a positive TB skin test?____________________
Yes No Recent cold, persistent cough? Sleep apnea? CPAP machine? ____________________________
Yes. No Do you smoke? Packs per day ______________ x's _____________ yrs. Quit when? ______________
Yes No Kidneys stones or kidney failure? ____
Yes No Hepatitis, jaundice, or liver problems? ____
Yes No Diabetes, diet or insulin controlled? ____
Yes No Bleeding disorders, hemophilia, sickle cell, blood clots in lungs or legs? ___________________________
Yes No Problems with back, neck or muscles? ____
Yes No Hiatal hernia, frequent heartburn, ulcers, indigestion? ______________________________________
Yes No Any family with a bad reaction to anesthesia? _______________________________________
Yes No Alcohol consumption. Amount daily or weekly? _______________________________________
Yes No Drug use, marijuana, cocaine, heroin? ____
Yes No Are you pregnant? If yes, are you breastfeeding? Yes No
Yes No Herpes, HIV +, other infectious disease? ____
Yes No Other history ____

The above is correct to the best of my knowledge. Patient's signature ________________________________

CHILDREN

Yes No Exposure to communicable diseases ____
Yes No Premature? Birth age? ____
Yes No Any problems at birth? ____
Yes No Breath holding spells? ____
Yes No Immunizations up to date? ____

The above is correct to the best of my knowledge. Parent signature _________________________________