CHO FOOT AND ANKLE SPECIALISTS

1. General information: Name _____ Age _____ Primary Care Doctor_____
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. Use back of paper to list any others.

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. Use back of paper to list any others.

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 Herpes, HIV +, other infectious disease? _____
Yes No Are you pregnant? How far along? _____
Yes No Are you breastfeeding? _____
Yes No Any other history _____

The above is correct to the best of my knowledge.

Patient/Parent signature _____ Date _____

MEDICAL ASSISTANTS USE ONLY

BP_____ PL_____ T_____ HGT_____ WGT_____
PROBLEM _____
_____
_____