CHO FOOT & 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.

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: 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? ____
Date and result of last Hemoglobin A1C: Date:_______________ Result:_______%
Yes No Flu Shot this year? Date administered: ________________________
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 or breastfeeding? ____
Yes No Any other history ____

Patients over the age of 65:
Yes No Advanced Care Plans in place? Name of Surrogate decision maker:___________________________________
Yes No Have you ever received a Pneumococcal Vaccine?

The above is correct to the best of my knowledge.

Patient/Parent signature ____ **Date** _________________________