Family Medical History:

Please mark which family member has/had the following health conditions:

Conditions:	Self: Please Explain	Father	Mother	
Anesthesia Problems?				
Arthritis?				
Asthma?				
Bleeding Disorders?				
Cancer (be specific)				
Diabetes?				
Gout?				
Heart Conditions?				
High Blood Pressure?				
High Cholesterol?				
Kidney Disease?				
Liver Problems?				
Lung Conditions?				
Neurological Issues (Alzheimer's Dementia, Parkinson's)				
Strokes?				
Gastrointestinal Issues? (gallbladder, IBS, GERD, Acid Reflux, Chron's, UC				

Social History:

***Marital Status:** _____

***Occupation** _____

***Number of Children**_____

***Caffeine Consumption:**
Yes No
Amount daily/weekly _____

***Alcohol Consumption**
Yes No
Drinks per week?_____

***Tobacco Use: Yes No**
_____**#packs per day**

***Weight:** _____ **lbs**

***Height:** _____ **ft** _____ **Inches**

Female: Any Pregnancy or Childbirth Issues/ Hysterectomy/Cancers? **YES / NO :** _____

Male: Any Prostate Issues (Cancer, Enlargement, ect)? **YES / NO ;**_____

**ONLY FOR Patients Over 65 yrs:

Do you have an Advanced Care Plan in Place? YES / NO If yes, please complete the following information:

Maker:_____

Contact Info:_____

Have you received a Pneumococcal Vaccine in the past 5 yrs? **YES / NO**

Have you or anyone in your household had a positive Covid-19 test? YES /NO

***Have you experienced any symptoms related to Covid-19? (fever/body aches/loss of taste or smell or trouble breathing) YES / NO**

****

The above information is correct to the best of my knowledge Patient/Parent

Signature:_____ **Date:** _____

CHO FOOT & ANKLE SPECIALIST

1. General information:

Name:____**Age:**__________
Primary Care Doctor:_______________________________ **Last date seen?**______________
Preferred Pharmacy:_______________________________ **Phone:**______________________

2. Please list any **Allergies** to food, **Medications or Latex:**______________________________

3. Please list all **medications you are currently taking, or have recently taken**. Include the dosage & be sure to include aspirin, blood thinners, cortisone, and over the counter drugs. **Please list below or provide a medication list.**
Please include: Supplements & Dosage:
____
____
____

4. **Please list any previous surgeries & dates:**
____
____
____

5. **Do you have a history of any of the following Circle "Yes" or "No". If "Yes", please comment.**

Yes No - TB or a positive TB skin test? ____
Yes No - Stroke, Seizures, Migraines, motion sickness?_______________________________________
Yes No - Currently taking antibiotics for dental procedures?_________________________________
Yes No - Asthma, Emphysema, wheezing, chronic bronchitis, COPD?____________________________
Yes No - Recent cold, persistent cough? Sleep apnea? CPAP machine?__________________________

Yes No - Kidneys stones or kidney failure?____
Yes No - Hepatitis, jaundice, or liver problems? *Explain:*____________________________________
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 - Herpes, HIV +, other infectious diseases?____
Yes No _ STD's or history of STI's____
Yes No - *Are you Pregnant?* Issues:____

Yes No - Seasonal Allergies? Medications?____
Yes No - Do you currently use or have a history of using, Marijuana, Cocaine, Heroin?____________

Yes No - Flu Shot this year? Date administered:____
Yes No- Diabetes, diet or insulin controlled?______________ Last A1C/Hemoglobin?______________

PLEASE CONTINUE TO OTHER SIDE >>>