KAISER PERMANENTE®

Please complete the attached medical questionnaire to the best of your ability before your Podiatric pre-op appointment. Please keep this in your folder which you need to bring with you to all appointments.

Podiatric Pre-Op Questionnaire

Age: ____ Sex: ____ Weight (lbs): _______ Height: ____ Occupation: ______________

Do you or have you ever had any of the following conditions? Check Yes or No
(Family, friends and relatives may help to complete this section)
Your interviewer will ask for the details.

	Yes	No
Heart: 1. Heart attack or angina (chest pains), treadmill test	___	___
2. Rhythm (skipped beats, missed beats, extra beats, palpitations, very fast heart rate)	___	___
3. Heart failure (fluid on the lungs)	___	___
4. Other (murmur, rheumatic fever, ankle swelling, shortness of breath when laying flat	___	___
Circulation (high blood pressure, low blood pressure, pain in the legs with exercise)	___	___
Lungs: 1.Asthma, bronchitis, or emphysema	___	___
2. Shortness of breath or cough	___	___
3. Recent cold involving the lungs (within 2 weeks)	___	___
4. Other Lung problems	___	___
Nervous system (stroke, seizure, numbness, weakness, headache; disease of the brain or spine)	___	___
Liver (hepatitis, cirrhosis, jaundice, gallbladder disease, or other problem	___	___
Kidney disease (difficult urination, infection, etc)	___	___
Diabetes (high or low blood sugars)	___	___
Thyroid disease	___	___
Stomach (ulcers, hiatal hernia, heartburn, reflux, diarrhea, constipation, bleeding with bowel Movements, abdominal pain)	___	___
Bleeding disorders (inability to stop bleeding once cut, or after dental procedures	___	___
Teeth (loose, chipped, capped, cracked, or removable)	___	___
Musculoskeletal System (back or neck pain, injuries, or arthritis	___	___
Skin (psoriasis, abrasions, bruises, ulcerations)	___	___
Cancer (ever received chemotherapy, radiation treatments)	___	___
(**For women**) Is there any possibility that you are pregnant at this time?	___	___
Other medical problems?	___	___

Podiatric Pre-Op Questionnaire

List all medicines that you have taken regularly anytime during the last six months. Include eye dropper, water pills, steroids and aspirin.

	Medicine	Dose	Frequency
1	______________	______________	______________
2.	______________	______________	______________
3.	______________	______________	______________
4.	______________	______________	______________
5.	______________	______________	______________
6.	______________	______________	______________

	Yes	NO
Do you have allergies or bad reactions to any medicines? (Please list medicines and your reaction to them).	___	___

____
____
____

List all previous surgeries (from the most recent)

	Type of Surgery	Type of Anesthesia (General, spinal, epidural, local)	Problems (With the anesthesia)	Date
1.	______________	______________	______________	________
2.	______________	______________	______________	________
3.	______________	______________	______________	________
4.	______________	______________	______________	________
5.	______________	______________	______________	________
6.	______________	______________	______________	________

	Yes	No
Has any blood relative of yours had a serious reaction to anesthesia?	___	___
Do you or have you ever smoked? ___________ packs/day for ___________ years	___	___
Do you drink alcohol? _________ oz. a day / week / month (circle one)	___	___
Do you or have you ever used drugs? (I.e. marijuana, cocaine, intravenous drugs)	___	___