Patient Medical History Form

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ORTHOPAEDICS

Title (please circle): Mr Mrs Ms Miss

First name: _____ **Surname:** _____

Height: _____ **Weight:** _____

Have you ever been diagnosed with any of the following:

- ☐ Angina
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Stroke or TIA
- ☐ Vascular disease/poor circulation
- ☐ Cancer
- ☐ HIV
- ☐ Hepatitis
- ☐ Blood Clots (deep vein thrombosis or lung clots)
- ☐ Bleeding problems
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Reflux
- ☐ Bowel disease
- ☐ Lymphoedema
- ☐ Chronic Pain Syndrome
- ☐ Rheumatoid disease
- ☐ Thyroid disease
- ☐ Sleep Apnoea

Please list all current medications including non-prescription:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list all current allergies:

_____

_____

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Have you ever previously encountered anaesthetic problems? YES / NO

Please describe:

_____

_____

Have you ever been admitted to Intensive Care? YES / NO

Have you ever had major surgery? YES / NO

Please list any major operations you have undergone in the past:

_____

_____

_____

Have you ever developed a major complication after a previous operation? YES / NO

Please describe:

_____

_____

Alcohol consumption - Number of standard drinks per day/week: _____

Nicotine consumption - Number of cigarettes or nicotine products per day: _____

Are you an ex-smoker? YES / NO **When did you stop smoking?** _____

Are you/could you be pregnant? YES / NO

Signature: _____

Print Name: _____ **Date:** _____ / _____ / _____