

Medical History

Date		
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Patient Name:	
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Patient D.O.B.		Age =	Over 70? (Please tick)
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Are you in good health?	Yes	No
Have you had any operations or serious illnesses in the past?	Yes	No
Are you currently attending a doctor, hospital clinic or Specialist?	Yes	No
Are you or could you be pregnant/	Yes	No

Do you have, or have had any problems with the following?

Breathing e.g. asthma, COPD, bronchitis shortness of breath or a persistent cough?	Yes	No
Heart e.g. heart attack, angina, murmur, a replacement valve or pacemaker, heart failure.	Yes	No
Blood pressure?	Yes	No
Blood e.g. anaemia, prolonged bleeding, bruising, sickle cell disease, thalassaemia?	Yes	No

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Stomach and gut e.g. ulcers, gastric reflux or colitis?	Yes	No
Kidneys, bladder or liver e.g. chronic infections, jaundice, or cirrhosis of the liver?	Yes	No
Nervous system e.g. epilepsy, stroke, Parkinsons or multiple sclerosis?	Yes	No
Hormones e.g. diabetes or thyroid?	Yes	No
Joints and bones e.g. arthritis or osteoporosis?	Yes	No
Skin e.g. eczema or psoriasis?	Yes	No
Mental health e.g. anxiety, depression, schizophrenia, bipolar, eating disorders?	Yes	No
Allergies or reactions to drugs, latex, food or metals?	Yes	No
Have you ever had or are having treatment for cancer e.g. chemotherapy or radiotherapy?	Yes	No
Could you have contracted an infection such as hepatitis, HIV, TB or CJD?	Yes	No
Do you have a learning disability?	Yes	No
Do you have a physical disability e.g. wheelchair use, visual or hearing?	Yes	No

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Have you ever had a bad reaction to general or local anaesthetic?	Yes	No
Do you have a yearly flu jab?	Yes	No
Is your BMI over 40	Yes	No

Are you taking any Medications or drugs which are prescribed, bought over the counter?	Yes – please list below	No
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Medication	Dose

Do you smoke, vape, use shisha or chew pan?	Yes – how much?	No
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Do you drink alcohol?	Yes _ how many units per week? 1 unit = ½ pint beer, small glass of wine, single measure of spirits	No
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Name:	Signature:	Date:
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