Pre-Admission Medical Questionnaire

If, for any reason, you object to fill out any or all of it, you may leave that part blank and provide us with the information you feel comfortable sharing with us.

First name:	Last name:
Procedure:	Admission date:
Male/female:	Date of birth:
Height:	Weight:

MEDICAL HISTORY

Please answer Yes or No, if Yes give dates, details and outcome.

Have you had any previous surgery in connection with this procedure? **Yes or No** _____

Please list any serious illness or operation or any current treatment

_____
_____

_____
_____

_____
_____

Do you take Aspirin or an Anticoagulant? Yes or No _____ Type and Amount_____

Please list prescription medicines Please advise dosage and amount per day

_____
_____

_____
_____

_____
_____

Have you had any problems with?

Allergies_____
_____

Anaesthetic or respiration_____

Drugs_____
_____

Do you suffer from?

High Blood Pressure_____

Diabetes_____
_____

Asthma_____
_____

Heart Disease or Angina_____

Phlebitis or Varicose Veins
_____

<u>Have you ever had?</u>

A Blood Transfusion or Coagulation problems_____

Stroke, Convulsion or Epilepsy_____

Stomach, Liver or Thyroid problems_____

Parkinson's Disease_____

Kidney failure or Rheumatic fever_____

Sciatica or Osteoarthritis_____

<u>Please advise if you have:</u>

False teeth, Hearing aid, Contact lenses_____

Do you smoke? Y/N amount_____ **units per week**

Do you drink alcohol? _____