exper + orthopaedics

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MEDICAL HISTORY FORM:

Name: _____ Height_____cm Weight_____kg

Do you have a pacemaker or any other metal in your body that may preclude you from having an MRI? Yes/No

Have you ever been diagnosed with any of the following?

- ☐ Angina or chest pain
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Hypertension (high blood pressure)
- ☐ Stroke or TIA
- ☐ Cancer
- ☐ HIV
- ☐ Hepatitis
- ☐ Blood clots
- ☐ Bleeding tendency
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Reflux
- ☐ Bowel disease
- ☐ Lymphoedema
- ☐ Chronic pain syndrome
- ☐ Rheumatoid disease
- ☐ Thyroid disease
- ☐ Autoimmune disease
- ☐ Infection with MRSA

Please list all current medications and frequency.

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

Please list all current allergies:

1._____ 3._____ 5._____
2._____ 4._____ 6._____

Please define your blood clot risk factors:

- ☐ Previous leg or lung clot
- ☐ Previous leg or lung clot in your family
- ☐ Elevated BMI
- ☐ Varicose veins
- ☐ Taking the pill/OCP or HRT
- ☐ Recent travel/surgery/immobility
- ☐ Smoking
- ☐ Pregnancy
- ☐ Cancer

Have you ever previously encountered anaesthetic problems?
Please describe:_____

Have you ever been told you have a difficult airway yes/no

Have you ever been admitted to intensive care? yes/no

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

Have you ever developed a major complication after a previous operation ?
Please describe:_____

Alcohol consumption: No of standard drinks per day :_____
Nicotine consumption: No of cigarettes or nicotine products per day:_____

What regular physical activities or sports do you participate in?

Signed: _____ Date:_____