MEDICAL HISTORY FORM

Name: ………………………………………………………………………………………

Weight: ……………………………… **Height**: ……………………………………

Please circle YES or NO if you have had any of the following conditions listed:

ANGINA	YES	NO
HYPERTENSION (high blood pressure)	YES	NO
DIABETES (high blood sugar)	YES	NO
RENAL DISEASE (kidney disease)	YES	NO
RESPIRATORY ILLNESS (lung problems)	YES	NO
BLEEDING DISORDER	YES	NO
HEPATITIS (liver disease)	YES	NO
HIV/AIDS	YES	NO
CANCER	YES	NO
RECENT VIRAL ILLNESS(flu-like illness)	YES	NO

If you answer YES for any of the above, please describe you treatment:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

…………………………………………………………………………

Do you have a past history of the following?

DEEP VEIN THROMBOSIS (blood clots in the leg)	YES	NO
PULMONARY EMOBLISM (blood clots in the lungs)	YES	NO
HEART ATTACKS	YES	NO
DIFFICULTIES WITH ANAESTHESIA	YES	NO

If you answer YES for any of the above, please provide details:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

What medications are you taking now?

……………………………………………………………………………………………………

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List any major operations you have had

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

Did you suffer any major complications from past operations?

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If you have a condition not listed above, please describe

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…………………………………………………………………………………………………
…………………………………………………………………………………………………

Are you allergic to any medications? Yes No

If Yes, please specify :

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

HABITS

Alcohol: Occasional OR number of drinks each day ……………………….

Smoking: Number each day ……………………
OR when did you quit? ………………………..

FEMALE HISTORY

Birth Control Pills YES NO

Hormone replacement therapy (HRT) YES NO

Signature ……………………………………………. Date …………………………