Dr Michael South

Medical History Form

Date: ..... **Name:** ..... **DOB**: .....

Please help me by filling in some basic details of your medical history. Previous conditions and operations can have significant bearing on your orthopaedic treatment - even those unrelated to your present condition. The information you supply will be treated in accordance with our practice privacy policy.

Height: ..... **Weight:** .....

Have you had any of the following? Please tick if you have.

- ☐ Heart attack or angina
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Kidney disease
- ☐ Anaemia
- ☐ Gout
- ☐ Asthma or lung problems
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Leukaemia
- ☐ Lupus
- ☐ Kidney or bladder infections
- ☐ Bowel disease
- ☐ HIV/AIDS
- ☐ Cancer

  If yes to Cancer, what sort? .....

  .....

Have you had any of the following? Please tick if you have.

- ☐ 1. DVT (deep venous thrombosis – blood clots in the leg)
- ☐ 2. Pulmonary embolus (blood clots in the lungs)
- ☐ 3. Excessive bleeding
- ☐ 4. Difficulties with anaesthesia
- ☐ 5. Family history of any of 1 to 4 above

Other medical conditions not listed above?

.....

.....

What medications are you taking now?

.....

.....

continued on page 2

Please list any operations you have had:

.....

.....

.....

.....

Have you had any major complications from those operations?

.....

.....

Do you have any allergies to medications or dressings? Please list and specify the reaction.

.....

.....

What is your usual occupation?

.....

Alcohol:

Approximate number of drinks per day during the week: .....

Approximate number of drinks over the weekend: .....

Cigarette usage: Approximate total life intake, plus time from cessation is useful to your treating surgeon, anaesthetist or physician.

Cigarettes per day: .....

For how many years: .....

If ceased, when: .....

Female History:

Contraceptive pill or implant: .....

Hormone replacement therapy: .....

Signed: .....