Medical History

Name:……..

Do you suffer from any of the following (please circle):

Angina (chest pain)	Epilepsy	Thyroid disease
Heart attack	Kidney disease	HIV/AIDS
Heart disease	Asthma	Previous reactions to anaesthetic
Heart murmur	Emphysema/COPD	Bleeding disorders
High blood pressure	Liver disease	Clots in the lung (PE)
Diabetes	Hepatitis B or C	Clots in the leg (DVT)
Stroke/TIA	Stomach ulcers/reflux	Cancer

Have you ever smoked?	Yes/No	No per day:……..
Have you quit?	Yes/No	If so when:……
Do you drink alcohol?	Yes/No	Units per day:……
Have you ever taken intravenous drugs?	Yes/No	
Have you ever had possible contact with:	Hepatitis B or C? Yes/No	
	HIV Yes/No	
Could you be pregnant?	Yes/No	

Please list any previous operations:	Please list all medications:

Please list any allergies: ……