

## Medical History Form

Name: \_\_\_\_\_ Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg BMI: \_\_\_\_\_

Do you have a pacemaker or any 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 ☐ Type 1 or 2
- Hypertension ☐
- Stroke or TIA ☐
- Cancer ☐ Type \_\_\_\_\_
- HIV ☐
- Hepatitis ☐ Type \_\_\_\_\_
- Blood clots ☐ Lung or leg Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- Bleeding tendency ☐
- Kidney disease ☐
- Lung disease ☐
- Reflux ☐
- Bowel disease ☐
- Lymphoedema ☐
- Chronic pain syndrome ☐
- Rheumatoid disease ☐
- Thyroid disease ☐
- Sleep apnoea ☐ Severity \_\_\_\_\_
- Infection with MRSA ☐ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list all current medications including non-prescription:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Please list all current allergies:

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

Please define your blood clot risk factors:

- |   |                          |                 |
|---|--------------------------|-----------------|
| ▪ Previous leg or lung clot yourself        | <input type="checkbox"/> |                 |
| ▪ Previous leg or lung clot in your family  | <input type="checkbox"/> |                 |
| ▪ Elevated body weight                      | <input type="checkbox"/> |                 |
| ▪ Varicose veins or surgery for VV          | <input type="checkbox"/> |                 |
| ▪ Taking the contraceptive pill or HRT      | <input type="checkbox"/> |                 |
| ▪ Recent travel/immobility in last 3 months | <input type="checkbox"/> |                 |
| ▪ Smoking                                   | <input type="checkbox"/> |                 |
| ▪ Pregnancy                                 | <input type="checkbox"/> |                 |
| ▪ Cancer                                    | <input type="checkbox"/> |                 |
| ▪ Recent surgery in last 3 months           | <input type="checkbox"/> | Total ____ / 10 |

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

Have you ever had major surgery? Yes / No

Please list any major operations you have undergone in 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 \_\_\_\_\_

Are you pregnant? Yes / No

What regular physical activities or sports do you participate in?

\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_