Medical History



Do you/or have you ever smoked? Yes / No oyou drink alcohol? Yes / No If yes, how ast operation/s		did you quit?			
	w many per week?				
'ast operation/s					
Past operation/s			Location (name of hospital)		
Have you or any relatives experienced proles. / No If yes, please describe the proble		ncluding conf	iusion)		
Do you have any reason to believe you ma	y be pregnant? Yes / No				
Oo You Suffer From Any Of The Follow		ease tick)			
) High Blood Pressure	() Bleeding disorders		() Stomach Ulcers / Reflux		
) Heart Disease	() Leg Cramps		() Epilepsy		
) Heart Attack	() Asthma / Airways Disease		() Liver disease / Jaundice		
) Angina / Chest Pain	() Bronchitis / Lung Disease		() Cancer	8	
) Heart Murmur / Valve Problems	() Diabetes		6	() Hepatitis B / C or HIV / AIDS	
) Stroke / TIA	() Thyroid Disease		() Mental Health Issues	5 '	
) Circulation problems	() Renal / Kidney Problems		() Rheumatic Fever		
Have you had any possible contact with HHIV / AIDS virus? Medication History: Do you take any of Blood thinning tablets: Aspirin/ Plavix/ Iso Dral Contraceptive Pill/ Hormone Replace Anti – arthritic medications (anti-inflamma Warfarin/ Heparin/ Clexane	the following? ocover ement Therapy		Yes / No		
Please list all current medications, includi					
Medication	Dose/ Freque	ency	Reason		
Allergies: medication / food / tape / latex	etc:		Reaction		
Allergy			Keaction		
Please provide below any additional inform					