Damiani Orthopaedics Medical History Form

First Name……..Surname……DOB……./……./……Date Completed……..

Past operations	Hospital	Year

Medications	Dose/Frequency	Reason

Please circle your response

DO YOU SUFFER FROM ANY OF THE FOLLOWING? (*Please Circle)*

High Blood Pressure	Bleeding disorders	Stomach Ulcers/Reflux	Heart Disease
Leg Cramps	Epilepsy	Heart Attack	Asthma/Airway Disease
Liver Disease/Jaundice	Angina/Chest Pain	Bronchitis	Hepatitis B or C
Heart Murmer	Diabetes	Mental Health Issues	HIV/AIDS
Stroke/TIA	Thyroid Disease	Renal/Kidney Problems	Rheumatic Fever

Do you take any of the following?

Asprin/Plavix/Isocover	Yes/No
Oral Contraceptive/Hormone Replacement Therapy	Yes/No
Anti-arthritic medication	Yes/No
Warfarin/Heparin/Clexane	Yes/No

Have you or any of your relatives experienced issues with anaesthetic/s? (*including confusion)* Yes/No

If so, please describe the problem……

Do you/or have you ever smoked? Yes/No If you have stopped, when did you quit?.....

Do you drink alcohol? Yes/No If yes how many per week?.....

Do you have any reason to believe you a pregnant? Yes/No

Have you ever had blood clots in your legs or lungs? Yes/No

If yes, when…… Treatment……

Has a member of your family ever suffered from blood clots in the legs or lungs? Yes/No

Have you ever had a blood transfusion? Yes/NO

If yes, when……..Any Problem /Reaction? Yes/No

Have you ever had any possible contact with: Hepatitis B Yes/ No HIV/AIDS Yes/No

Do you suffer from any allergies? Yes/NO

If yes please list below

Allergy	Reaction