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PATIENT MEDICAL QUESTIONNAIRE

Surname: _____ Name: _____
Date of Birth: _____ Height: _____ Weight: _____

Please indicate as follows:

Heart disease	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Pulmonary disease	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No
Renal disease	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Cholesterol	☐ Yes ☐ No

Did you or do you suffer from any thyroid gland disorder or thyroid hormone disorder? ☐ Yes ☐ No
Has an electrocardiograph been made recently? ☐ Yes ☐ No
Do you suffer from allergies? ☐ Yes ☐ No
If yes, which ones? _____

Do you suffer from diabetes?	☐ Yes ☐ No	Do you suffer from anaemia?	☐ Yes ☐ No
Are you prone to bruising?	☐ Yes ☐ No	Blood diseases?	☐ Yes ☐ No
Jaundice/Hepatitis	☐ Yes ☐ No	Infections?	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Cancer?	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	HIV?	☐ Yes ☐ No

Have you ever had a problem with local or general anaesthetic? ☐ Yes ☐ No
Have you ever had any problems with bleeding? ☐ Yes ☐ No
Do you suffer from allergies against any medication? ☐ Yes ☐ No
If yes, which ones? _____

Have you ever suffered from severe diseases or accidents? ☐ Yes ☐ No

If yes, explain _____

Do you take the following medication regularly?

Aspirin / Anti-inflammatory	☐ Yes ☐ No	Tranquilizers	☐ Yes ☐ No
Diuretic tablets	☐ Yes ☐ No	Blood pressure tablets	☐ Yes ☐ No
Cholesterol tablets	☐ Yes ☐ No	Pain-killers	☐ Yes ☐ No
Herbal Remedies	☐ Yes ☐ No	Anti-retrovirals (ARV's)	☐ Yes ☐ No

Do you have one or more of the following habits?

Smoking ☐ Yes ☐ No If so, how many? _____

Have you undergone any surgical interventions? (including cosmetic surgery) ☐ Yes ☐ No
If so, which ones?, when? Where? _____

What medication do you take at present? _____

Date: _____ Signature: _____