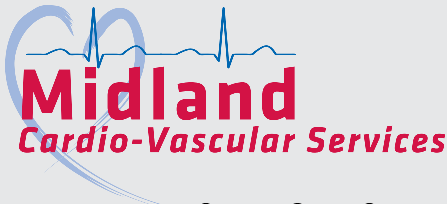
Name: DOB:



PLEASE AFFIX PATIENT DETAILS
LABEL HERE

HEALTH QUESTIONNAIRE

FAMILY HISTORY HAS ANY OF YOUR BLOOD RELATIONS EVER HAD:

YES	NO	Bleeding or clotting disorders	YES	NO	Inherited muscular disorder

PERSONAL HISTORY HAVE YOU EVER HAD OR DO YOU HAVE:

YES NO **ALLERGIES or SENSITIVITIES**

Have you ever had an allergic reaction or been sensitive to any drugs, iodine, sticking plaster, foods etc?

Sensitivity or Allergy	Nature of Reaction	Severity
Drug/Medication/Substance	*ie Rash/Swelling/Anaphylaxis/Diarrhoea*	*Mild/Moderate/Severe*

YES	NO	Anaemia	YES	NO	Heart attack/angina/chest pain
YES	NO	Any antibiotic resistant infection	YES	NO	Hepatitis A, B or C
YES	NO	Arthritis	YES	NO	High blood pressure
YES	NO	Asthma	YES	NO	HIV
YES	NO	Blackouts or severe headaches	YES	NO	Kidney disease
YES	NO	Bladder infections	YES	NO	Neuromuscular illness
YES	NO	Bleed or bruise easily	YES	NO	Rheumatic fever
YES	NO	Blood clots in the legs or lungs	YES	NO	Shortness of breath
YES	NO	Cough or bringing up sputum	YES	NO	Sight impairment
YES	NO	Convulsions or fits	YES	NO	Stroke
YES	NO	Diabetes	YES	NO	Swollen ankles
YES	NO	Epilepsy	YES	NO	Tuberculosis
YES	NO	Hearing difficulties	YES	NO	Unusual thumping or beating of the heart
YES	NO	Do you snore?	YES	NO	Do you stop breathing when you sleep and/or have sleep apnoea?
YES	NO	Other illnesses (please specify)	YES	NO	Problems with anaesthetics (please specify)

YES	NO	Previous surgery (please specify)

YES	NO	Do you smoke?	How many cigarettes per day?
YES	NO	Do you drink alcohol?	How many alcoholic drinks per day?
YES	NO	Do you use recreational drugs?	What and how often?

YES	NO	Have you been in a hospital or health care facility overseas in the last 6 months?
YES	NO	Have you previously been found to be infected or colonised with MRSA?
YES	NO	Have you been in contact with COVID in the last 2 weeks?

YES	NO	Do you have any physical, emotional, spiritual, cultural, dietary or communication needs that we need to know about? If yes, please specify.
YES	NO	**Females** - is there a possibility you might be pregnant? (X-rays during surgery or anaesthetic drugs may cause harm to your baby)
YES	NO	Is there anything else we need to know about you or your medical history or individual needs that will help us to plan the best care for you? If so please specify.
YES	NO	Do you have any mobility issues, use any mobily aids? (eg. walking stick or frame).
YES	NO	Have you had any falls in the last 2 months?