REC – PATIENT MEDICAL HISTORY

PATIENT NAME: **D.O.B: / /**

ALLERGIES	**NO**	**YES**	**Comments**
Do you have any allergies to medications, food, sticking plaster, latex/rubber or other substances ?			

ALL REGULAR MEDICATIONS	Dose/ Freq	**ALL REGULAR MEDICATIONS**	Dose/ Freq

PREVIOUS OPERATIONS / PROCEDURES

What is your:	Height	Weight	BMI

Do you have or have you ever had any of the following conditions ?

Please circle if appropriate:						Details
Diabetes:	Diet	Tablets	Insulin	Yes	No	
Cancer				Yes	No	
Stroke / TIA				Yes	No	
High Blood Pressure				Yes	No	
Heart attack / Chest pain / Angina				Yes	No	
Palpitations / Irregular heart beat / Heart murmur				Yes	No	
Pacemaker / Prosthetic heart valve / any other heart condition				Yes	No	
Blood clots in your lungs, legs or a bleeding disorder				Yes	No	
Arthritis				Yes	No	
Liver Disease / Hepatitis (Type A,B,C)				Yes	No	
Kidney problems				Yes	No	
Epilepsy / Fits / Blackouts				Yes	No	
Asthma / Bronchitis / Pneumonia				Yes	No	
Do you have sleep apnoea				Yes	No	
Have you or any family members had a reaction to an anaesthetic				Yes	No	
Ulcers or breaks in your skin				Yes	No	
Have you ever had MRSA or VRE				Yes	No	
Have you had a fall in the last year				Yes	No	
Do you have an Advanced Care Directive				Yes	No	
Glaucoma				Yes	No	