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Medical History Questionnaire

Name			
Sex	Age	Height	Weight

Do you suffer from, or is there a history of, the following? Tick either "yes" or "no" and, if any answer is "yes", provide a detailed explanation.

	YES	NO
1. Cardiovascular disease		
• High blood pressure		
• Heart failure		
• Heart valve lesion, rheumatic fever, or congenital heart disease		
• Dysrhythmia, palpitations (without exertion), or black outs		
• Shortness of breath when lying down, or walking on a level surface		
If any answer is "yes", please provide a detailed explanation:		

2. Central nervous system disease		
• Epilepsy, fits (convulsions), or giddiness		
• Depression or psychosis		
If any answer is "yes", please provide a detailed explanation:		

3. Blood disorders		
• Anaemia, sickle cell disorder, or thalassaemia		
• Abnormal bleeding associated with previous dental extractions, surgery or trauma, or do you bruise easily?		
If any answer is "yes", please provide a detailed explanation:		

4. Blood clots		
• Episodes of thrombosis, or embolism of the legs or lungs?		
If the answer is "yes", please provide a detailed explanation:		

5. Respiratory disease		
• Do you smoke?		
• History of snoring		
• Lung disease, e.g. asthma, emphysema, TB		
If any answer is "yes", please provide a detailed explanation:		

6. Endocrine disorders		
• Diabetes mellitus		
• Thyroid problems		
• Porphyria or other metabolic disorders		
If any answer is "yes", please provide a detailed explanation:		

7. Liver disease		
• Hepatitis, jaundice		
• Other liver disease		
If any answer is "yes", please provide a detailed explanation:		

8. Kidney disease		
• Renal disease or disorders, or renal failure		
If the answer is "yes", please provide a detailed explanation:		

9. Muscle disorders		
• Myopathy, dystrophy or progressive weakness, or malignant hyperthermia		
If the answer is "yes", please provide a detailed explanation:		

10. Arthritis and orthopaedic problems		
11. Stomach problems		
• Indigestion, heartburns, hernia, or ulcers		
12. Hereditary disease in the family		
13. History of allergy in general, or allergic reactions to medications		
14. Previous admission to hospital		
15. Previous operations		
16. History of taking medication or drugs, including herbal remedies and recreational drugs		
17. Previous adverse or unpleasant reaction to anaesthesia		
18. Infectious diseases		
19. Airway problems		
20. Failed sedation		
If the answer is "yes", please provide a detailed explanation:		
21. Is there anything you would like to discuss, but would prefer not to write down?		
If the answer is "yes", please contact your sedationist and discuss this with him/her before the date of your procedure		

FOR OFFICIAL USE ONLY
When did the patient last eat or drink?
Date:
Signature: