DR RAZVAN STOITA

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Height _____ cm/ft-ins Weight _____ kg/st-oz

Do you have or have you had any of the following conditions? Please answer every question.

Problems with Anaesthesia? ☐ YES ☐ NO If yes, explain _____

Current Complaints _____ Date of Last Tetanus _____

Allergies / Side Effects with Medication & Reaction ☐ None ☐ Latex ☐ Metal /Jewelry

Current Medication

How Taken ☐ None

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

	YES	NO
Arthritis	☐	☐
Blood Transfusions	☐	☐
Blood Thinners please circle Aspirin Plavix Warfarin Antiinflammatories Other: …….		
Cancer If yes, details……..	☐	☐
Cortisone Injections If yes, how many……	☐	☐
Cardiac Conditions: Heart attack	☐	☐
Cardiac Conditions: Irregular heart	☐	☐
Cardiac Conditions: Heart murmur	☐	☐
Cardiac Conditions: Heart Surgery	☐	☐
Cardiac Conditions: Pacemaker	☐	☐
Cardiac Conditions: Stents	☐	☐
Cardiac Conditions: High blood pressure	☐	☐
Cardiac Conditions: High Cholesterol	☐	☐
Depression or Anxiety If yes, medication……	☐	☐
Diabetes Controlled by: Diet	☐	☐
Diabetes Controlled by: Oral medication	☐	☐
Diabetes Controlled by: Insulin	☐	☐
Diabetes Controlled by: Recent HbA1c level:		
Epilepsy/Seizures	☐	☐
Hormone replacement or birth control	☐	☐

	YES	NO
Gastric Conditions: Stomach Ulcer	☐	☐
Gastric Conditions: Reflux/Gastritis	☐	☐
Lung conditions: Asthma	☐	☐
Lung conditions: Emphysema	☐	☐
Lung conditions: Pulmonary embolus	☐	☐
Lung conditions: Sleep apnoea, If yes, CPAP……	☐	☐
Liver conditions: Hepatits If yes, type:…….	☐	☐
Liver conditions: Enlarged liver	☐	☐
Liver conditions: Cirrhosis	☐	☐
Haematological (bleeding) disorders If yes, details:……	☐	☐
Neck or back pain/injuries	☐	☐
Stroke	☐	☐
Thyroid conditions	☐	☐
Urinary conditions: Kidney failure	☐	☐
Urinary conditions: Bladder problems	☐	☐
Urinary conditions: Enlarged prostate	☐	☐
Venous conditions: Thrombosis(DVT)	☐	☐
Venous conditions: Varicose veins	☐	☐
Smoking ☐ No ☐ Ex-smoker ☐ Yes, ……pack(s)/day Alcohol ☐ No ☐ Yes, No of drinks/day…… Recreational drugs ☐ No ☐ Yes, which ones…….. Other Conditions:……..		

Are there any other specialists involved in your care?_____

Have you had any previous surgery? Include dates if possible._____

_____

I hereby certify that the medical information I have provided above is true and accurate to the best of my knowledge.

Sign_____Date_____