

ORTHONORTH PATIENT HEALTH QUESTIONNAIRE

NAME (Mr/Mrs/Ms/Miss/Mstr//Dr/Prof) _____ DOB / /

What is your: **Height** cm/ ft/ins **Weight** kgs /lbs

ALLERGIES	NO	YES	
Do you have allergies to medications, food, sticking plaster, latex/rubber (e.g. balloons, gloves) or other substances?			Details:
MEDICATIONS	NO	YES	
Do you take any anticoagulant or blood-thinning therapy? (Warfarin, Coumadin, Plavix, Iscover)			Date last taken / / or still take <input type="checkbox"/> Yes
Do you take any steroids, anti-inflammatory drugs or cortisone tablets / injections?			Name of medication: Date last taken: / /
REGULAR MEDICATIONS not listed above	DOSE	REGULAR MEDICATIONS not listed above	DOSE

PREVIOUS OPERATIONS / PROCEDURES					
Operation	Year	Surgeon	Operation	Year	Surgeon

Do you have, or have you had, any of the following conditions?	NO	YES	
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure			Managed by: <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin
Cancer			Site:
Stroke			Date / /
High blood pressure			
Heart attack / coronary / chest pain / angina (please circle)			
Palpitations / irregular heart beat / heart murmur			
Pacemaker / prosthetic heart valve / any other heart condition			Specify:
Blood clots in a lung or leg or bleeding disorder? (You or a family member).			
Arthritis - Rheumatoid Arthritis or Osteoarthritis (please circle)			
Thyroid problems			
Liver disease / hepatitis			Specify type: A, B, C
Kidney / bladder problems			
Hiatus hernia / gastrointestinal ulcers / bowel disorder / reflux			
Epilepsy / fits / blackouts			
Depression / dementia / other mental illness			
Migraines			
Asthma / bronchitis / pneumonia / hay fever (please circle)			
Do you have sleep apnoea?			If yes, state treatment:
Do you ever have shortness of breath?			<input type="checkbox"/> Walking less than 50 metres <input type="checkbox"/> Climbing stairs / inclines <input type="checkbox"/> Lying flat
Have you any wounds or breaks on your skin?			
Have you ever had MRSA or VRE?			
Have you ever been involved in a "look back" for CJD or alternatively received an "In Medical Confidence" letter notifying you of a potential exposure to CJD?			
Do you have any other conditions or infections that may require further explanation?			