PATIENT HISTORY FORM

Patient Information

Date --

Name Surname -- Date of Birth --

Phone -- E-Mail --

Height -- Weight --

Nationality ------------------------ Languages --

Address --

Details of Confidant

Name Surname -- Date of Birth --

Phone -- E-Mail --

Nationality ------------------------ Languages --

Address --

Condition / Disease

- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Hip Dysplasia
- [ ] Tumor
- [ ] Traumatic Injury : --
- [ ] Other --

Condition/Disease Exists Since --

Pre-existing Diseases

Next
New Steps

Medical Information

Do you have allergies to medications, latex, or food?

☐ NO ☐ YES: ____________________

Do you have history of smoking?

☐ NO ☐ YES: ____________________

Do you now have, or have you ever had, the following medical problems?

- ☐ Heart Attack/Heart Failure
- ☐ Chronic Kidney Disease
- ☐ Chest pain, pressure, squeezing
- ☐ Arrhytmia / Palpitations
- ☐ Cold or Flu within last 2 weeks
- ☐ Liver Disease: Hepatitis/Jaundice
- ☐ Blood Disorders / Diseases
- ☐ Lupus (SLE) / Multiple Sclerosis
- ☐ Tuberculosis / Pneumonia
- ☐ Diabetes
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke / Mini Stroke
- ☐ Asthma
- ☐ Prostate Disorder
- ☐ Seizures / Epilepsy
- ☐ Anemia
- ☐ COPD

Do/did any of your family have any of the following?

- ☐ Rheumatoid Arthritis
- ☐ Other Joint problems
- ☐ Bleeding problems
- ☐ Anesthesia problems
- ☐ Mental Illness
- ☐ Heart Attack
- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Thyroid Disease

Other severe accidents or diseases / NOTES

Medical Information

Please write your symptoms (pain, swelling, limitation of movement)

Please list every operation that you have had under anesthesia

Please list all of your current medications

Reviewer

Name	
Surname	
Result (Y/N)	
Estimated Stay	

Notes

Next
New Steps