HEALTH QUESTIONNAIRE

Height:

Weight:

Occupation (If retired, what did you do?):

Sports / hobbies:

Are you Left or Right handed or Ambidextrous?

☐ Left Handed ☐ Right Handed ☐ Ambidextrous

Please provide your past medical history:

Diabetes:

☐ Yes ☐ No ☐ Type I ☐ Type II

DVT/PE

☐ Yes ☐ No

Epilepsy:

☐ Yes ☐ No

Asthma

☐ Yes ☐ No

Heart Conditions:

☐ Yes ☐ No

Other Condition:

Have you had any previous surgery?

Pacemaker, Y/N

☐ Yes ☐ No

Stents, Y/N

☐ Yes ☐ No

Previous orthopaedic surgery?

☐ Yes ☐ No

Any cortisone injections?

☐ Yes ☐ No

Other Surgical Procedures:

Have you had any problems with a previous anaesthetic?

☐ Yes ☐ No

If so, please describe:

Please provide a list of your current medications:

Pain medications

☐ Yes ☐ No

Blood thinners (such as Aspirin/ Warfarin/ Plavix,):

☐ Yes ☐ No

Glucosamine Y / N

☐ Yes ☐ No

Other:

Other Information:

Are you a smoker?

☐ Yes ☐ No ☐ Quit

If Yes, how many per day & how many years?

If Yes, are you aware that smoking has serious adverse effects on skin and bone healing?

☐ Yes ☐ No

Do you have any allergies?

☐ Yes ☐ No

If so, please list:

Have you had physiotherapy?

☐ Yes ☐ No

If Yes, where and how many sessions?

Do you live alone?

☐ Yes ☐ No

If No, with?

☐ Spouse/Partner ☐ Parent/s ☐ Friend

Do you have someone close to you that can help you recuperate?

☐ Yes ☐ No