ENT North

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Surname .....

Given Name(s) .....

Date of Birth .....

AFFIX PATIENT LABEL HERE

Height.....**Weight** .....

PAST MEDICAL HISTORY	**Yes**	**No**
Anaemia	☐	☐
Arthritis	☐	☐
Asthma / Bronchitis / Emphysema	☐	☐
Bleeding problems	☐	☐
Blood clots in legs / lungs (DVT)	☐	☐
Cancer: location	☐	☐
Caps / Crowns / Dentures	☐	☐
Chest Pains / Angina / Palpitations	☐	☐
Depression / Anxiety attacks	☐	☐
Diabetes	☐	☐
Epilepsy / Fits	☐	☐
Heart Problems / Heart Attack	☐	☐
Hepatitis / Jaundice	☐	☐
Hiatus Hernia / Gastric reflux	☐	☐
High Blood Pressure	☐	☐
Indigestion / Heart Burn	☐	☐
Kidney Problems	☐	☐
Liver Disease	☐	☐
Lung Infections / Pneumonia	☐	☐
Neck or Jaw problems	☐	☐
Pacemaker	☐	☐
Persistent Cough	☐	☐
Prostate Problems	☐	☐
Rheumatic fever / Heart murmur	☐	☐
Shortness of breath	☐	☐
Skin problems: Rashes/Ulcers	☐	☐
Sleep apnoea	☐	☐
Stomach ulcers	☐	☐
Stroke	☐	☐
Swollen ankles	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Disabilities	☐	☐

If yes .....

Current Medications including Herbal/non-prescribed/recreational/tablets/vitamins

Please List

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	Yes	**No**
Blood Thinning Tablets	☐	☐

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	Yes	**No**
Allergies / Reactions	☐	☐
Latex	☐	
Tapes	☐	
Anaesthetics	☐	
Tablets - list which ones	☐	

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	Yes	**No**
Have you had any blood products or transfusion in the last 3 months?	☐	☐

Date .....

	Yes	**No**
Smoking		
How many per day	☐	☐
Alcohol	☐	☐

Average daily intake .....glasses

Have you had previous Surgery?

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	Yes	**No**
Females: Are you pregnant?	☐	☐
Are you breast feeding?	☐	☐

(adapted from Austin Health Preadmission Documentation, with thanks)