



MEDICAL SUMMARY FORM –Page 1

PATIENT INFORMATION:

PATIENT'S NAME:

SEX:

TELEPHONE :

FAX NUMBER:

EMAIL:

PROCEDURE / SURGERY REQUESTED:

MEDICAL HISTORY

PREVIOUS OPERATIONS:

ANAESTHETIC PROBLEMS:

ALLERGIES:

CURRENT MEDICATIONS:

ATTACH ADDITIONAL SHEET IF REQUIRED

CHECKLIST OF PREVIOUS ILLNESSES

MEDICAL CONDITIONS	YES / NO
BLOOD PRESSURE – HIGH	YES / NO
BLOOD PRESSURE – LOW	YES / NO
HEART DISORDER (ANGINA, CONGENITAL, THROMBOSIS, FEVER, RH)	YES / NO
DIABETES	YES / NO
KIDNEY / BLADDER RELATED	YES / NO
LIVER CONDITIONS, JAUNDICE	YES / NO
ULCERS (GASTRIC, DUODENAL) DIARRHEA, HIATUS, HERNIA)	YES / NO
ASTHMA, TB, BRONCHITIS, LUNG DISEASE	YES / NO
VARICOSE VEINS, THROMBOSIS OF VEINS	YES / NO
PORPHYRIA (PATIENT OR MEMBERS OF FAMILY)	YES / NO
EPILEPSEY, ANY MUSCULAR OR NEUROLOGICAL DISPRDERS	YES / NO
ORTHOPEDIC PROBLEMS	YES / NO
EXCESS BLEEDING POST-SURGERY OR INJURY	YES / NO
TROPICAL DISEASES, MALARIA ETC	YES / NO
ANY RECENT MINOR ILLNESSES	YES / NO



MEDICAL SUMMARY FORM – Page 2

FEMALE PATIENTS

MENSTRUAL CYCLE: Regular / Irregular

CYCLE LENGTH:

LMP:

PILL: No / Yes Type:

NUMBER OF PREGNANCIES:

NUMBER OF MISCARRIGES:

DISCHARGE:

MENOPAUSE: No / Yes

AGE:

HARMONE TREATMENT: No / Yes Type:

PATIENT CURRNTLY PREGNANT: Yes / No

If you feel there are any further details which may help us in providing you with the appropriate treatment / surgery please specify below: (Please use additional sheet if space not sufficient)

If you have recent copies of x-rays, scans, diagnosis reports and medical reports from radiologists or consultants in you possession these would be useful to our consultants and surgeons.

The information I have provided is true and accurate and to the best of my knowledge.

Signed.....

Date.....