

Dr Vytauras Kuzinkovas

Advanced Surgicare

Medical History

Personal History (Have you ever suffered from any of the following health problems?)			
Illness	Yes	No	Details:
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type I <input type="checkbox"/> Type II <input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>	Do you use a CPAP device? Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease / Angina	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Clotting Disorder/Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Other: (Please specify)			

Other	
Have you ever smoked? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, how many?
How long?	Have you/when did you stop?
How many standard alcoholic drinks do you have per week?	

Surgical History (Please give details of any past operations, especially abdominal)	
Procedure:	Date:

Family History (Please list any conditions that run in your family)

Medications (Please state all medications that you are on)		
Medication:	Dose:	Duration:

Name: _____