Appendix 4:

Medical history questionnaire

Confidential medical history

This information is vital for us to ensure that we can make your conscious sedation (CS) safe. Please read and answer every question truthfully and provide us with details where needed.

Reference (Office Use Only)

Your Details

Title | Surname | First Name | Date of birth (DD/MM/YYYY)

Mobile or Landline | Email

Height | Weight | Occupation

Details of your GP or Consultant

Name and address of your specialist or doctor

Telephone | Email

Current medication

Please provide a full list of all prescription and / or alternative medication (including herbal) that you are currently taking.

Current medication

Please tick all boxes / conditions that apply to you and provide details.

General

- I am smoking __ cigarettes per day
- I stopped smoking __ years ago
- I consume about __ units of alcohol per week
- I am presently using recreational drugs
- I easily get skin rashes
- I've had a sedation before
- I've had general anaesthetics
- I've had a spinal or epidural anaesthetic

Women

- I am or could be pregnant
- I am taking oral contraceptives
- I am presently breast feeding

Allergies

- Penicillin
- Any other antibiotics
- Aspirin
- Painkillers
- Elastoplast
- Sedatives (please specify)
- Sleeping pills
- Latex
- Local anaesthetics
- Food allergy
- Anything else?

Have you or have you had any of the following conditions? Please provide details for all that apply!

- AIDS/HIV positive
- Anaphylaxis
- Anaemia / Low blood count
- Angina
- Anxiety
- Arthritis
- Artificial heart valve
- Asthma
- Blood disorders
- Breathing problems
- Bruising tendency
- Cerebral palsy
- Chest pains
- Convulsions
- Depression
- Diabetes (insulin dependent)
- Diabetes (Type II)
- Drug addiction
- Emphysema / COPD
- Epilepsy or seizures
- Excessive bleeding
- Excessive thirst
- Faints / Dizziness
- Frequent cough
- Frequent diarrhoea
- Frequent headaches
- Glaucoma
- Gout
- Haemophilia
- Hay fever
- Heart attack
- Heart failure
- Heart murmur
- Heart pacemaker
- Heavy snoring
- Hepatitis B or C
- Hereditary diseases
- High blood pressure
- High cholesterol
- Indigestion
- Irregular heartbeat
- Kidney problems
- Learning difficulties
- Leukaemia
- Liver disease
- Low blood pressure
- Low blood sugar
- Lung disease
- Muscle weakness
- Porphyria
- Psychiatric care
- Recent weight loss
- Reflux
- Rheumatic fever
- Sickle cell disorder
- Sleep apnoea
- Steroid medicine
- Stomach ulcers
- Stroke
- Swelling of limbs
- Thalassaemia
- Thyroid disease
- Yellow jaundice

- **Any other conditions not listed? Please note them below**

- **Please tick this box if there is anything you wish to discuss with your seditionist in confidence**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in medical status.

Name of Patient or Guardian	Date (DD/MM/YYYY)	Signature of Patient or Guardian