

Name: _____
(Last Name) (First Name)

NHI: _____ DOB: _____

Gender: _____

PATIENT HEALTH HISTORY

Date: / /

Weight: _____ kg Height: _____ cm

Do you have any allergies or sensitivities to any medications, food, latex, sticking plasters or other? Y N

Medication/Substance Name	Type of Reaction

- 1 Have you ever smoked? Y N
If no, go to question 3

- 2 Do you currently smoke? Y N
If yes, how many a day, for how many years and how long ago?

- 3 Do you drink alcohol? Y N
If yes, how much and how often?

- 4 Do you take street drugs or narcotics other than those prescribed for you? Y N
If yes, please describe:

- 5 Do you have any vision or hearing difficulties? Y N
If yes, please describe:

- 6 Do you have any religious beliefs/practices or cultural needs we should be aware of? Y N
If yes, please describe:

- 7 Do you have any skin problems (eg. ulcers, bruise easily, wounds or dressings)? Y N
If yes, please describe:

- 8 Mobility: Independent Using Equipment Requiring Assistance Completely Dependent

9 Do you take any regular medications? (Including the contraceptive pill, inhalers, herbal remedies, pain medication, eye-drops, sprays or regular over-the-counter medications such as aspirin) **List Below**

Medication	Strength (mg)	Dose (how many)	Frequency (how often)



Name: _____
(Last Name) (First Name)

NHI: _____

(Do you suffer from or have you ever had any of the following?) Please answer all the questions

10 Hepatitis A Hepatitis B Hepatitis C Yellow Jaundice HIV

11 Hiatus Hernia Heartburn Acid Reflux

12 High blood pressure? Y N

If Yes, is this being monitored/treated by your GP?

13 Heart problems (eg. heart attack, angina, irregular pulse, fluid on lungs, **PACEMAKER**,
rheumatic fever, palpitations, fainting, murmur, endocarditis)? Y N

If Yes, please list:

14 A stroke (eg. CVA, or TIA)? Y N

15 Blood clots to legs or lungs? Y N

16 Blood disorders: (eg. anaemia, Von Willebrands disease)? Y N

If Yes, please explain:

17 Lung problems (eg. asthma, recent bronchitis, emphysema, TB)? Y N

18 Arthritis? Y N

19 Fits or seizures (eg. epilepsy)? Y N

If Yes, when was your last seizure?

20 Diabetes? Y N

If Yes, what treatment are you on? Diet Tablets Insulin

21 Are you, or could you, be pregnant? Y N

22 Have you had any joint replacement surgery? Y N

If Yes, which joints:

23 Any other medical conditions? Y N

If Yes, please specify:

Discharge Planning

24 Do you live alone? Y N

25 Do you have caring responsibilities for others at home? Y N

26 Would you like to be given information about cancer support services? Y N