Minnaar Sedation (Pty) Ltd
REG NO: 2013/096441/07

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Medical History Questionnaire:

[Patients must please download, complete and email (info@minnaarsedation.co.za) / fax(086 552 0749) the following form prior to the procedure or bring it along on the day of the procedure.]

Name: _____

Gender: _____ Age: _____ Weight: _____kg Height: _____

PAST MEDICAL HISTORY:

Have you ever been admitted to hospital? Y / N
If yes, please supply details: _____
_____

Cardiovascular

Do you suffer from high blood pressure? Y / N
If yes, what was you last blood pressure reading: _____/_____
Do you suffer from heart failure, ischemic heart disease e.g. angina, heart attack? Y / N
Do you suffer from heart valve lesion, rheumatic fever, congenital heart disease? Y / N
Do you suffer from dysrhythmia, palpitations (without exertion), blackouts? Y / N
Do you become short of breath when lying down or walking on a level surface? Y / N
If yes, please supply further details: _____

Respiratory

Do you snore? Y / N
Do you suffer from lung disease e.g. asthma, emphysema, TB? Y / N
If yes, please supply further details: _____

Abdominal

Do you suffer from indigestion, heartburn, hernia or ulcers? Y / N
Do you suffer from hepatitis or jaundice? Y / N
If yes, please supply further details: _____

Central nervous system

Do you suffer from epilepsy, fits (convulsions)? Y / N
Do you suffer from depression, psychosis? Y / N
Have you had a stroke? Y / N
If yes, please supply further details: _____

Blood disorders

Do you suffer from anaemia, sickle cell disorder, thalassemia, etc.? Y / N
Have you had abnormal bleeding associated with previous extractions, surgery or trauma or do you bruise easily? Y / N
Have you had thrombosis/embolism in the legs or lungs? Y / N
If yes, please supply further details: _____

Endocrine
Do you suffer from diabetes? Y / N
If yes, please give details of medication and degree of control: (Glucose control, Hb1Ac)
_____
Do you suffer from thyroid problems? Y / N
Do you suffer from porphyria or other metabolic disorders? Y / N
Renal
Do you suffer from kidney disease / renal failure? Y / N
Musculoskeletal
Do you suffer from myopathy, dystrophy or progressive weakness? Y / N
Do you suffer from arthritis or orthopeadic problems? Y / N
Infectious Diseases
Do you suffer from any infectious diseases (HIV/Hepatitis)? Y / N

PAST SURGICAL HISTORY:
Have you ever had an operation? Y / N
If yes, please supply full details: _____
Have you ever had any adverse/unpleasant reaction to anaesthesia?(For example: failed sedation, failed intubation, airway problems or malignant hyperthermia) Y / N
If yes, please supply full details: _____

MEDICATION:
Do you take any medication (drugs), including herbal and recreational drugs? Y / N
If yes, please supply full details: _____

FAMILY HISTORY:
Are there any hereditary diseases in your family? Y / N
If yes, please supply full details: _____

SOCIAL HISTORY:
Do you smoke? Y / N. How much? _____ cigarettes/day. For the past _____ years.
Do you drink alcohol? Y / N
Amount: _____(number) of _____(type) per day
or _____ of _____ per week?
Female: Are you pregnant or is there any possibility that you might be pregnant? Y / N

ALLERGIES:
Do you suffer from allergies(especially any allergy to medication)? Y / N
If yes, please supply full details: _____

Is there anything you would like to discuss but prefer not to submit here? Y / N
(If you tick yes, please contact your sedationist and discuss this with him/her before the date of your sedation)

Name of designated driver who will take the patient home: _____
Relationship of driver (example: mother, father, friend): _____
Mobile phone number of the designated driver: _____

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(Signature of patient or guardian in case of minor)