Age Concern Luton Patient Questionnaire

PLEASE COMPLETE THIS FORM IN BLACK INK

Title		Surname	
First Name		Date of Birth	
Known As		Occupation	

Home Address	Work Address
Postcode	Postcode
Telephone No.	Telephone No.
Doctor's Name & Address	Doctor's Telephone Number

	Questions	Yes	No	Relevant Details
	A. Are you?			Please continue on the back of the form
1)	Likely to be pregnant?			
2)	Receiving any medical treatment?			What For?
3)	Taking any prescription medication?			Which?
4)	Allergic to any drugs or substances?			
	B. In the past have you?			
1)	Ever been told that you have a heart problem, angina,			
2)	Ever had rheumatic fever?			When?
3)	Ever had Jaundice, hepatitis, liver problems or kidney			
4)	Ever had any serious chest infections, diseases or			
5)	Ever had any blood related diseases?			
6)	Ever had a bad reaction to local or general anesthetic?			
7)	Ever had an operation or hospital treatment?			Details?
8)	Ever had a heart valve replaced?			When?
9)	Ever had blood refused by the blood transfusion			
	C. Do you?			
1)	Have arthritis?			
2)	Have a pacemaker?			
3)	Have or ever had fainting attacks, giddiness or			
4)	Or any blood relatives in your family have diabetes?			
5)	Carry a warning card?			Type?
6)	Bruise easily or bleed excessively?			
7)	Take steroids or taken them in the last 12 months?			When and how long?
8)	Do you smoke? If yes how many per day?			
	Previous Smoker ? No per Day? When Quit?			
9)	Do you drink alcohol? If so how many units per week?			

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2) Receiving Medical Treatment Details

3) Medication Taken

7) Hospital Treatment / Operation

8) Other Details

SIGNED…….. DATE…….