kaapsevoetchirurgie
capefootsurgery

# Medical History – Please Complete

***Do you suffer from (yes/no)***

| | | |
|---|---|---|
| Heart disease (including angina / infarction) | ☐ **Yes** | ☐ **No** |
| Blood pressure | ☐ **Yes** | ☐ **No** |
| Cholesterol | ☐ **Yes** | ☐ **No** |
| Pacemaker | ☐ **Yes** | ☐ **No** |
| Asthma | ☐ **Yes** | ☐ **No** |
| Kidney Disease | ☐ **Yes** | ☐ **No** |
| Porphyria | ☐ **Yes** | ☐ **No** |
| Stroke | ☐ **Yes** | ☐ **No** |
| DIABETES | ☐ **Yes** | ☐ **No** |
| SMOKING | ☐ **Yes** | ☐ **No** |
| PREVIOUS DVT (Thrombosis/Pulmonary embolus) | ☐ **Yes** | ☐ **No** |

Other medical problems

_____

_____

***Do you use medication:***

| | | |
|---|---|---|
| Hormone replacement | ☐ **Yes** | ☐ **No** |
| Blood thinners (Aspirin/Ecotrin/Warfarin/other) | ☐ **Yes** | ☐ **No** |

Other medications _____

_____

***Known allergies to medication:***

_____

_____ _____ _____

**DATE** **NAME** **SIGNATURE**