CHECKLIST FOR MEDICAL TRAVEL - PATIENT MEDICAL HISTORY

Date: _____
Patient's Full Name: _____
Procedure: _____
Address: _____
Contact Number: _____

Undergoing surgery or treatments could have risks and health complications that need to be correctly understood by clinicians. In order to minimize these, it is important to give accurate and full information about your medical history and status of health.
Please fill up this form and submit at least three weeks prior to the procedure to determine whether or not you are fit to undergo surgery.

PAST MEDICAL HISTORY

1. Describe your past medical history? _____
_____

2. Have you undergone any surgical procedures? Yes No
If yes, please specify and give date/s of procedure:
_____
_____

3. Have you undergone any cosmetic surgical procedures? Yes No
If yes, please specify and give date/s of procedure:

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4. Have you had General Anesthesia? Yes No

5. Have you had Local Anesthesia? Yes No

6. Did you have any adverse reaction with the Anesthesia, Surgery or Recovery period?

Yes _____ No _____

Angina ____ Blood Clots in Legs ____ Heart Attack ____ Pacemaker (cardiac) ____
Pulmonary Embolism ____ Stroke ____ Congestive Heart Failure _____
Asthma ____ Frequent Pneumonia ____ Diabetes ____ Hepatitis ____
Jaundice (skin turns yellow) ____ High Blood Pressure ____ Bronchitis____
Easy Bruising Tendency ____ Prolonged Bleeding ____ Recurrent Infections ____
Poor Wound Healing ____ Keloids____ Heart Rhythm Disturbances ____ Blood Disorder _____

7. Are you allergic to any medication? Please check any medications(s) which you are allergic to:
Yes _____ No _____

Aspirin ____ Codeine ____ Demerol ____ Erythromycin ____ Ketamine____
Lidocaine ____ Morphine ____Neosporin / Fucidin Ointment ____Tylenol ____
Penicillin ____Valium ____Sulfa ____ Marcaine ____
Others (please specify): _____

8. Have you been tested for HIV virus? Yes No
If yes, what was the result of the test?
_____

9. Have you ever been diagnosed of Hepatitis A, B, C, D, E or G? Yes ____ No ____
If yes, please specify and give date/s of diagnosis:
_____
_____

10. Are you allergic to: Adhesive Tape____ Iodine____

CURRENT HEALTH STATUS

1. Mention **ALL** medications & pills you are taking with dosage & duration:

_____
_____
_____

2. Do you have any ongoing conditions?
Yes ____ No _____
If yes, please specify and give date/s of diagnosis: _____
_____ _____
_____
3. Has your weight increased or decreased in the last year? Yes No current weight:
_____ height: _____ BMI: _____

4. Are you undergoing any emotional stress? **If yes**, please describe:
_____

5. How do you rate your tolerance to pain/ discomfort?
Please encircle: Very low Low Fair High Very High

6. Do you have any bleeding or other blood disorders?
Yes ____ No ____
If yes, please specify the disorder and describe any treatment you have undergone:
_____
_____

7. Do you smoke? Yes ____ No ____
If yes, Since when? _____ How often? _____ Sticks per day:_____

8. Do you consume alcoholic beverages? Yes ____ No ____
If yes, state how may units of alcohol you drink per day. (One unit = half a glass of beer, one single shot of spirits or one glass of wine)
_____

For Women Only:
1. When was your last menstrual period?
_____
2. Are you on any oral contraceptives? Yes ____ No ____

3. Are you Pregnant? Yes ____ No ____
If you feel there is anything else of relevance to your medical history that we should know please mention this –

Kindly specify the date you prefer to undergo the procedure:_____
Preferred destination _____ ; 2nd Choice as a destination: _____
Patient's Signature: _____ Date: _____

Please email a scanned copy of the completed checklist to info@hbb.ae