PIVET MEDICAL CENTRE
The Miracle Of Life

New Patient ☐

Updated Form ☐

PLACE PATIENT LABEL HERE

MALE PATIENT - HEALTH AND HISTORY QUESTIONNAIRE

Previous Operations

DATE	OPERATION	FINDINGS	HOSPITAL

Past Fertility History

Do you have any children? Yes ☐ No ☐

Number of children:

Relevant Family History

Number of siblings

Medical history:

Please tick YES or NO to the following questions and give details where required	YES	NO
Do you have any problems relating to anaesthetic? *Details:*	☐	☐
Does anyone in your family have a history of anaesthetic problems? *Details:*	☐	☐
Have you had any serious illness or accidents? *Details:*	☐	☐
Have you ever had a blood transfusion? *Details?*	☐	☐
Do you smoke? If yes - how long for?_____ How many per day?_____ If previously a smoker when did you quit?_____	☐	☐
Do you drink alcohol? ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ RARELY *(please tick)*	☐	☐
Have you ever had a sexually transmitted disease? *Genital Herpes* ☐ *Chlamydia* ☐ *Gonorrhea* ☐ *Syphilis* ☐ *Hep B* ☐ *Hep C* ☐ *HIV /AIDS* ☐ *Genital Warts* ☐ *Human Papillomavirus (HPV)* ☐ *Donovanosis* ☐	☐	☐
COVID-19 Vaccination Status ☐ Fully Vaccinated ☐ Partially Vaccinated ☐ Unvaccinated ☐ Do not wish to disclose	☐	☐

MEDICAL CONDITIONS

Have you ever had or do you currently have any of the following conditions? Please tick the relevant boxes:-

☐ Nil Medical Conditions

☐ Diabetes
☐ High Blood Pressure / Low Blood Pressure

☐ Elevated cholesterol
☐ Pacemaker
☐ Congestive Heart Failure
☐ Rheumatic Fever
☐ Respiratory Disease
☐ Asthma
☐ Emphysema / Airway Disease
☐ Depression / Anxiety + ☐ Medication
☐ Managed by GP ☐ Managed by Psychiatrist
☐ History of confusion, memory loss / dementia
☐ History of multi-drug resistant organisms *(MRSA, VRE, CRE)*
☐ Arthritis

☐ Urinary / Bowel problems

*Specify*_____

☐ Tendency to bruise
☐ Kidney Disease
☐ Stroke or TIA
☐ Blood Disorder / Clots in lungs or legs

*Specify*_____

☐ Thyroid problems
☐ Epilepsy or Fits
☐ Other medical conditions or not already mentioned

i.e. Lap Banding (inflated / deflated)Please circle

*Specify*_____

☐ Skin problems such as sores, skin tears, bruises, blisters, rashes, dermatitis, eczema pressure sores or recent tattoos?

*Specify*_____

☐ History of a Fall in the last 6 months
☐ Require glasses / hearing aid

MEDICATIONS	ALLERGIES
(please list)	*(please tick and specify allergic reaction)*
☐ Nil	☐ Nil
	☐ Medications
	☐ Latex
	☐ Sticking Plaster / Tapes
	☐ Dyes / Lotions
	☐ Foods

CURRENT WEIGHT	HEIGHT	BMI (OFFICE USE ONLY)
_____*kgs*	_____*cm*	

DECLARATION

I acknowledge having received, read and understood a copy of the PIVET Medical Centre Privacy Guide, which explains how the Centre will handle my personal information.

I hereby declare that the information provided by me in this form is true and correct

Patient Name: Signature: Date:

Form Reviewed	Initials	Signature
Doctor		
Clinic Nurse		
Theatre Nurse		

FORM RENEWAL DATE	
DATE FORM COMPLETED:	
DATE OF RENEWAL:	