dr du toit
DR ALJ (JACQUES) DU TOIT ORTHOPAEDIC SURGEON
MBChB, MMed Orth, FC Orth (SA)
MP Nr: 0679500 | PR Nr: 0280000678856

Past Medical & Surgical History Information

Name: _____ **Date of Birth: _____/_____/_____**

Past Medical History:

Please check the boxes of any current or past medical problems that you have had.

- ☐ Alcoholism / Drug abuse
- ☐ Aneurysm
- ☐ Angina
- ☐ Anaemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone / Joint Infections
- ☐ Blood Clots / DVT
- ☐ Blood Clotting Disorder
- ☐ Cancer
- ☐ Chemotherapy / Radiation
- ☐ Cholesterol
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Depression
- ☐ Emphysema / COPD
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack / Myocardial Infarction
- ☐ Heart Valve Disease
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ High Blood Pressure / Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism / Underactive Thyroid
- ☐ Kidney Disease / Failure
- ☐ Kidney Stones
- ☐ MRSA Infection
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Reaction to Anaesthesia
- ☐ Seizures
- ☐ Sleep Apnoea
- ☐ Stomach Ulcers / Peptic Ulcer Disease
- ☐ Stroke / TIA
- ☐ Tuberculosis

Please list any other conditions and details of marked above:

_____
_____
_____
_____
_____

Allergies:

Please select all medications or substances that you are allergic to:

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ Contrast Dyes
- ☐ Adhesive tape / Dressings / Plasters
- ☐ Other: _____ _____ _____

Family History:

Are you aware of any congenital or hereditary conditions in your family:

_____
_____
_____
_____

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List of Medications and Dose:

Are you on any of the following medications:

- ☐ Warfarin
- ☐ Xarelto / Rivaroxiban
- ☐ Aspirin
- ☐ Anti-Platelet Medication e.g. Clopidogrel (Plavix)

Please list all medications including over the counter medicines, herbals and prescription medications that you take:

Medication Name	**Dose & Frequency**

Past Surgical History:

Please list all of the operations that you have had in your lifetime:

Operation *(Please indicate left/right if applicable)*	**Year**

Social History:

Do you smoke / use tobacco products:

- ☐ Yes — If Yes, how many per day: _____ — For how many years: _____
- ☐ No
- ☐ I did, but stopped

What level of activity is required at your workplace:

- ☐ Mild desk job
- ☐ Moderate standing, lifting
- ☐ Extensive manual labour
- ☐ Other: _____
- ☐ Work Restrictions: _____

Do you or a family member have any problems with anaesthesia:

- ☐ Yes
- ☐ No
- ☐ Elaborate: _____

Females: Are you pregnant or suspect that there might be a chance that you are pregnant?

- ☐ Yes
- ☐ No

Patient Signature: _____ **Today's Date:** _____/_____/_____