Medical History Form – Dr David Duckworth

Full Name:	

Please circle YES if you have or NO if you do not have any of the medical conditions listed:

Angina (chest pain)	YES	NO	HIV / AIDS	YES	NO
Heart attack	YES	NO	Cancer	YES	NO
Hypertension (high blood pressure)	YES	NO	Seizures	YES	NO
Diabetes (high blood sugar levels)	YES	NO	Thyroid problems	YES	NO
Renal disease (kidney disease)	YES	NO	DVT (blood clots in the leg)	YES	NO
Respiratory illness (lung problems)	YES	NO	PE (blood clots in the lung)	YES	NO
Bleeding disorder	YES	NO	Difficulties with anaesthesia	YES	NO
Hepatitis (liver disease)	YES	NO			
Other:					

List any operations you have had in the past:

Did you suffer any major complications after previous operations?

List any medications you are currently taking:

Do you have any allergies?

Do you smoke?	NO	YES	No. of cigs each day:	When did you quit?
Do you drink any alcohol?	Never	Social		No. of drinks each day:
Have you ever used intravenous drugs?			YES	NO

Shoulder/Elbow Questionnaire

Hand Dominance (Please Circle): Right / Left / Ambidextrous

Date your shoulder / elbow problem began: _____

Were you injured at work? Yes / No

In your own words, please describe your current shoulder / elbow problem:

_____

_____

_____

If you have had an injury, please describe it in detail:

_____

_____

Do you currently have problems with any of the problems listed below. If so, please describe:

Shoulder / Elbow stiffness: _____

Shoulder / Elbow weakness: _____

Shoulder / Elbow instability: _____

Have you had any operations on your shoulder / elbow? Please list procedure & date:

_____

_____

Have you had any cortisone injections around your shoulder / elbow? If so, how many?:

_____