**HM patient questionnaire – xxxxxxx SURGERY**

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| **Today's date:** |  |
| **Name of procedure:** |  |
| **Why is the procedure needed/desired? What is the main complaint/disease?** |  |
| **Detailed description + timeline of main complaint/disease until now (symptoms, hospitalizations, medications, procedures):** |  |
| **Was the procedure recommended by a physician (indicate their specialty)? If not, why/how has the patient decided on this specific procedure?** |  |
| **Age + date of birth:** |  |
| **Sex:** |  |
| **Height (cm):** |  |
| **Weight (kg):** |  |
| **Any known diseases - heart disease, stroke, diabetes, hypertension, hypercholesterolemia, etc. (since when? + how is it being treated?):** |  |
| **Any surgeries (dates + details):** |  |
| **Any hospitalizations (dates + details):** |  |
| **Any medications (specifically blood clotting medications):** |  |
| **Smoking:** |  |
| **Allergies:** |  |
| **Medical files** | |
|  | **(Received, not yet received, not available)** |
| **Complete medical summary from physician/s** |  |
| **Blood tests - CBC (complete blood count), chemistry, blood clotting tests, etc.** |  |
| **Studies - X-ray, CT, MRI, ultrasound, gastroscopy, colonoscopy, laparoscopy, UGI (upper gastrointestinal) series, biopsy, etc.** |  |
| **Any additional files** |  |