

Patient MDI check list

Name: _____ Age: _____

Address: _____

Physician: _____ Tel _____

Specialist (if consult required) _____ Tel _____

Medical history (tick box if condition present).

List current & recent medication & treatments:

(eg. anti coagulants, steroids, anti depressants, hormone replacement therapy, bisphosphonates, chemotherapy, radiotherapy).

CONDITION	MEDICATION
<input type="checkbox"/> Allergies (eg local anaesthetic, antibiotics)	_____
<input type="checkbox"/> Diabetes (controlled or unstable)	_____
<input type="checkbox"/> Osteoporosis or Paget's Disease	_____
<input type="checkbox"/> Blood disorder (list)	_____
<input type="checkbox"/> Cardiovascular Disease	_____
<input type="checkbox"/> Joint pain or arthritis	_____
<input type="checkbox"/> Lung Disorders (TB, asthma, emphysema,)	_____
<input type="checkbox"/> Cancer (list)	_____
<input type="checkbox"/> Addiction (drugs, alcohol, tobacco)	_____
<input type="checkbox"/> Mental state (confused, depressed, memory poor)	_____
<input type="checkbox"/> Other	_____

