โรงพยาบาลกรุงเทพ
BANGKOK HOSPITAL
พัทยา • PATTAYA

Patient Assessment Form

PATIENT INFORMATION

Preferred Title:….. First Name: …… Surname: …… Gender: ……
Date of Birth: …… Nationality: …….. Passport No.: ……
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Widower
Blood Group: …… Weight (kg): …… Height (cm): …… BMI: ……..
Telephone No.: …… E-Mail Address: ……
Address: …… Suburb: …… City: ……
State: …… Postcode: …… Country: ……..

Person to notify in case of emergency:

Full Name: …… Relationship: ……..
E-Mail Address: …… Telephone No.: ……..

CURRENT HEALTH CONDITION

Underlying Conditions

☐ Cardiovascular disease	☐ Heart Disease	☐ Hypertension	☐ Hypotension
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism
☐ HIV	☐ Hepatitis B	☐ Deep vein thrombosis	☐ Cancer
☐ Adrenal insufficiency	☐ Multiple sclerosis	☐ Keloid scarring	☐ None

Please specify your condition(s): ……
Other diseases not mentioned: ……..

CURRENT MEDICATIONS AND SUPPLEMENTS

☐ NSAIDs	☐ Aspirin	☐ Steroids	☐ Anti-Anxiety
☐ Coumadin/Warfarin, Heparin	☐ Accutane	☐ Fish Oil	☐ Vitamin E
☐ Diet Pills	☐ Sleeping Tablet	☐ None	

Others, please specify: ……
If you are taking any medication: How often? (dose per day):
……
When was the last time you took it?: ……..

ALLERGIES

Drug Allergy: ☐ Yes ☐ No If yes, please specify: ……
Food Allergy: ☐ Yes ☐ No If yes, please specify: ……

*** SEE OVER PAGE FOR FURTHER DETAILS

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PAST ILLNESSES

Underlying Condition

☐ Cardiovascular disease	☐ Heart Disease	☐ Hypertension	☐ Hypotension
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism
☐ HIV	☐ Hepatitis B	☐ Deep vein thrombosis	☐ Cancer
☐ Adrenal insufficiency	☐ Multiple sclerosis	☐ Keloid scarring	☐ Skin Infection
☐ Bleeding Problem	☐ None		

Please specify your condition(s): .....

Other diseases not mentioned: .....

PAST SURGICAL HISTORY

Have you had any surgery before? ☐ Yes ☐ No

If yes, please specify:
1) ..... Year: .....
2) ..... Year: .....
3) ..... Year: .....
4) ..... Year: .....
5) ..... Year: .....

Have you had anesthesia side effects? ☐ Yes ☐ No

If yes, please specify: .....

FAMILY MEDICAL HISTORY

☐ Cardiovascular disease	☐ Heart Disease	☐ Hypertension	☐ Hypotension
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism
☐ HIV	☐ Hepatitis B	☐ Deep vein thrombosis	☐ Cancer
☐ Adrenal insufficiency	☐ Multiple sclerosis	☐ Keloid scarring	☐ Skin Infection
☐ Bleeding Problem	☐ None		

Please specify your condition(s): .....

Other diseases not mentioned: .....

PSYCHOLOGICAL HISTORY

Alcohol Intake ☐ Yes ☐ No

Frequency (e.g. daily, occasionally): ..... Amount (glasses/bottles): .....

Smoking ☐ Yes ☐ No

Number of Cigarettes per Day: .....

Please note: Smoking can delay your healing process after any surgery. It is recommended you stop smoking 2 weeks prior to your surgery.

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REPRODUCTIVE HISTORY

Last Menstrual Period: ……

Please note: It is recommended you do not schedule your surgery during your menstrual period.

Contraceptive Pills: ☐ Yes ☐ No Last Taken: ……..……...

Last Pregnancy: ☐ Normal ☐ Caesarean Section Year: ……..……...

Last Breast feeding: ……

Number of Children: ……

Plans for Future Pregnancy: ☐ Yes ☐ No

TERMS AND CONDITIONS

- I hereby acknowledge that the questions on this form have been answered truthfully.
- It is my responsibility to inform Bangkok Hospital Pattaya of any change in my medical status.
- I fully understand that providing incorrect and/or incomplete information can lead to:
  (1) Serious risks to my health;
  (2) Cancellation of my treatment(s);
  (3) Extra pre-operative and post-operative treatment(s) and/or examination(s) necessary for my condition(s); and
  (4) Additional cost of the treatment(s) and/or examination(s) stated in (3).
- If you have or had any health condition, you are willing to send Bangkok Hospital Pattaya your medical history along with this form.

☐ **I accept the terms and conditions stated above.**

[_____]

(Signature)

DATE: …../……/……