



PRE-ADMISSION DETAILS & MEDICAL HISTORY

Expected date of arrival: (dd)-(mm)-(yyyy)

Expected date of Admission: (dd)-(mm)-(yyyy)

Name of the present consulting doctor/physician: _____

Recent diagnosis of the doctor/physician: _____

Current medication:

Drug Name	Strength (mg)	Dose/Frequency

Diagnostic reports attached:

Diagnostic Report	Specifications of the tests	Year of diagnosis	Impressions
Pathology			
Radiology			
MRI			
CT-Scan			
PET-Scan			
X-Ray			



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Please complete the following. Mark "X" for the correct answer:

Do you have any health problems? If Yes, please describe. (Yes) (No)

Have you had any major surgery? If Yes, please describe. (Yes) (No)

Have you any major injuries? If Yes, please describe. (Yes) (No)

Do you take any medications/nutritional supplements/herbal medications? If Yes, please describe: (Yes) (No)

Have you ever had any adverse reaction to local or general anesthesia? (Yes) (No)

Do You take Aspirin/Blood Thinners? (Yes) (No)

Have you had an allergic reaction to medication? If Yes, what type and what year? (Yes) (No)

Do you have any known allergies? If Yes, please describe. (Yes) (No)

Do you have any bleeding problems? If Yes, please describe. (Yes) (No)

Do you smoke? If Yes, how much? (Yes) (No) _____

Do you take alcohol or other recreation medicines/drugs? If Yes, please describe. (Yes) (No)

Are You Pregnant / Lactating?(only for Female Patients) (Yes) (No)

Do you have any children? If Yes, how many, and how old is the youngest? (only for Female Patients) (Yes) (No)

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The following questions concern you and your family. Please "X" for yourself and/or state which Family Member has the problem.

	Self		Family Member
	Yes	No	
Neurological Disorder?			
Diabetes?			
Heart Problems?			
Breathing / Lung Problems?			
Gastrointestinal problems?			
Kidney Problems?			
Do you have any skin problems/skin cancer? If Yes, please describe in the space below.			
Other medical problems, including communicable diseases? If Yes, please describe in the space below.			

INSURANCE COVERAGE (if any):

Kindly furnish the insurance coverage details of your health insurance policy:

I hereby declare that the facts stated above are true to the best of my knowledge and belief. I have no objection to my health records at Revita Healthcare being made available at revitahealthcare.com

Signature/impression of the Patient

Signature/impression of the Attendant

Name of the Patient

Name of the Attendant