BAC Medical Tourism

INTERNATIONAL MEDICAL TOURISM CENTER

Medical History Questionnaire

First Name:
Last Name:
Marital Status:
Occupation:
Specify pregnancies, birth, abortions:
Children Ages:
Address:
Postcode:
Country, State:
Language Spoken:
E-mail:
Telephone # Home:
Telephone # Business:
Mobile # :
Date of Birth:
Age:
Gender:
Passport Number:
Current Weight:
Current Height :
BMI:
Cholesterol level:
Proposed Date for arrival:
Local Physician:
Telephone # :
What type of surgery or treatment are you interested in?
Reason you wish to have this surgery/treatment?
Previous Surgeries Undergone and date.
Where you satisfied with results? Why?
How is your health in general?
Do you smoke? How often?
Do you drink alcohol? How often?
Nervous System alterations or illness:
Sleep Apnea:
How often do you snore?
Do you feel sleepy during the day?
Migraine:
Any negative experience with anesthetics? If yes, please specify:

Allergies:
Hormones:
Blood Pressure High:
Blood Pressure Low:
Heart Disorders:
Diabetes:
Kidney or Bladder disorder :
Osteoporosis:
Arthritis or joint pain?
Liver Conditions:
Reflux:
Heartburn:
Ulcers:
Asthma Etc:
Cataracts:
Back problems:
Lung Disorder:
Stomach Disorders:
ENT complaints:
H.I.V. /AIDS:
Cancer:
Hepatitis or liver disease:
Anemia or bleeding:
Clotting disorder:
Diabetes type I or type II
Vascular problems? **Such as varicose veins, etc:**
Porphyria:
Epilepsy Etc:
Orthopedic Problems:
Dental procedures needed? **Please specify:**
Excess Bleeding:
Current Medication, milligrams, how often and purpose:
Tropical Diseases:
Any Recent Illness:
Comments :