Medical History

Dr Adrian Low

Patient Name: _____ **Date of birth** _____ **Age** _____

Height: _____ **cm / ft-ins** **Weight:** _____**kg / st-oz**

Do you have or have you had any of the following conditions? Please answer every question

	Yes	No
Arthritis	☐	☐
Blood Transfusions	☐	☐
Blood Thinners *please circle* — Aspirin Warfarin Anti Inflammatories Herbal Medicines		
Cancer, *if yes, details* _____	☐	☐
Cortisone Injections, *if yes, how many* _____	☐	☐
Cardiac conditions — Cardiac Surgery	☐	☐
Pacemaker / Stent	☐	☐
Heart Attack/s	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Depression or Anxiety, *if yes, medication* _____	☐	☐
Diabetes *controlled by* — Diet	☐	☐
Tablets	☐	☐
Insulin	☐	☐
Epilepsy *if yes, tablets* _____	☐	☐

	Yes	No
Elevated Cholesterol / Triglycerides	☐	☐
Gastric Conditions — Stomach Ulcer	☐	☐
Indigestion / Reflux	☐	☐
Kidney Conditions *if yes, details*_____	☐	☐
Neck or back injuries / problems	☐	☐
Lung Conditions — Asthma	☐	☐
Emphysema	☐	☐
Sleep Apnoea *if yes, CPAP* _____	☐	☐
Smoking *if yes, how many per day* _____	☐	☐
Liver Conditions — Hepatitis *if yes, what type* _____	☐	☐
Alcohol Consumption *if yes, how many per week* _____	☐	☐
Stroke/s	☐	☐
Thyroid Conditions	☐	☐
Venous Conditions — Thrombosis (DVT)	☐	☐
Varicose Veins	☐	☐
Other, *details* _____		

Are there any other specialist involved in your care? _____

_____

Have you had any previous surgery?, *include dates if possible* _____

_____

What are your current medications?, *including herbal remedies* _____

_____

Do you have any allergies to medications, metals or other? _____

_____

Next of Kin

Name _____ Relationship _____ Phone Number _____

I hereby certify that the medical information I have provided above is true and accurate to the best of my knowledge.

Sign and date: _____