# Medical History

Dr Ali Gursel

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

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

| Condition | | 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<br>if yes, CPAP ______ | ☐ | ☐ |
| | Smoking<br>if yes, how many per day ______ | ☐ | ☐ |
| Liver Conditions | Hepatitis<br>if yes, what type ______ | ☐ | ☐ |
| | Alcohol Consumption<br>if yes, how many per week ______ | ☐ | ☐ |
| Stroke/s | | ☐ | ☐ |
| Thyroid Conditions | | ☐ | ☐ |
| | Thrombosis (DVT) | ☐ | ☐ |
| | Varicose Veins | ☐ | ☐ |
| Other, details ______ | | | |

Are there any other specialists 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: ______________________