Medical History

Please assist us in providing the best possible service and treatment by providing the following information. Please see the receptionist if you require any assistance.

Patient Details

Medical History

☑ Please tick if you have ever had any of the following:

- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer or a Mastectomy
- ☐ Depression
- ☐ Diabetes (diet, tablet or insulin controlled)
- ☐ Emphysema or any other lung problems
- ☐ Do you smoke? If so, how many per day? _____
- ☐ Epilepsy
- ☐ Heart murmur
- ☐ Heart attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cortisone injection
- ☐ Kidney trouble
- ☐ Stomach trouble or indigestion
- ☐ Thyroid trouble
- ☐ Deep vein thrombosis (DVT)
- ☐ Varicose veins
- ☐ Blood transfusion
- ☐ Blood thinners
- ☐ Hepatitis
- ☐ Tattoos

Please list any allergies to medications _____

_____

Please list any previous knee surgery _____

_____