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Medical History

Please answer every question

	Yes	No		Yes	No
Arthritis ( ) Osteo ( ) Rheumatoid					
Blood transfusions **Blood thinners** ( ) Aspirin ( ) Warfarin ( ) Herbal Medicines			**Liver conditions** ( ) Hepatitis ( ) A ( ) B ( ) C ( ) **Alcohol consumption** Per day Per week ( ) **Tattoos**		
Cancer If yes, where & when diagnosed?			**Mental health** e.g. Depression, Anxiety		
Cardiac conditions **Date**: ( ) Cardiac Surgery/stents ( ) Heart Attack/s ( ) Heart Murmure ( ) High Blood Pressure			**Stomach conditions** ( ) Ulcer ( ) Indigestion		
Diabetes Type ..... ( ) Diet ( ) Tablets ( ) Insulin			**Stroke/s** Date/s		
Epilepsy			**Thyroid conditions** ( ) Hyper - active ( ) Hypo - active		
Kidney conditions Medication/s			**Venous conditions** ( ) Thrombosis / DVT/ PE ( ) Varicose Veins		
Lung conditions ( ) Asthma ( ) Emphysema ( ) Cigarettes Per day			**Cortisone injections** ( ) Site ( ) Number/frequency		

Previous surgery

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Current Medications ( ) See LMO letter dated ……(if listed on referral)

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Allergies to medication , metals or other.....

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

Sign & Date .....