## **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			
Medio	cal History		
	Please tick if you have ever had any of the following:		
	Asthma		Stroke
	Arthritis		Stomach trouble or indigestion
	Cancer or a Mastectomy		Cortisone injection
	Depression		Kidney trouble
	Diabetes (diet, tablet or insulin controlled)		Thyroid trouble
	Emphysema or any other lung problems		Deep vein thrombosis (DVT)
	Do you smoke?		Varicose veins
	If so, how many per day?		Blood transfusion
	Epilepsy		Blood thinners
	Heart murmur		Hepatitis
	Heart attack		Tattoos
	High Blood Pressure		
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- F - -	Please list any previous surgery		
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