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

Condition		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* ____________		☐	☐

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 *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? ________________________

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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: ________________________