 **MEDICAL HISTORY**

**Title:** \_\_\_\_ \_\_ **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ **DOB:** \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postcode:** \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**email :** \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

**Home Phone:** \_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ **Work Phone:** \_\_\_ \_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile:** \_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party** *(If not self)* \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Contact in case of Emergency:** \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ph:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your General Medical Practioner?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Ph:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YES / NO** *(Please Tick the appropriate box)*

🞏 🞏 **Are you allergic to anything?** *e.g.**Penicillin Erythromycin Metals Amoxicillin Latex Codeine Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

🞏 🞏 **Are you taking any blood thinning medication?** *(Please list name of medication in medication table below)*

🞏 🞏 **Have you ever taken any medication containing Bisphosphonates?** *(Please list name of medication in medication table below)*

🞏 🞏 **Ladies are you Pregnant?** *If yes when is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_*

🞏 🞏 **Ladies are you Breastfeeding?**

**Please Tick** any Conditions below that you *have or have had*:

|  |  |  |
| --- | --- | --- |
| **Heart Complaints**  *Yes No*  🞏 🞏 Heart Murmur  🞏 🞏 Pacemaker  🞏 🞏 Heart Valve Disorder  🞏 🞏 Artificial Heart Valves: *When*:\_\_\_\_\_\_\_\_  🞏 🞏 Stents: *When*:\_\_\_\_\_\_\_\_\_  🞏 🞏 Rheumatic Fever  🞏 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Vascular Conditions**  *Yes No*  🞏 🞏 Stroke  🞏 🞏 High Blood Pressure  🞏 🞏 Low Blood Pressure  **Organ Conditions**  *Yes No*  🞏 🞏 Thyroid Disease  🞏 🞏 Kidney Disease  🞏 🞏 Diabetes : Type:\_\_\_\_\_\_\_\_ | **Lung Conditions**  *Yes No*  🞏 🞏 Do you smoke?  🞏 🞏 Asthma: *Inhaler* *Yes / No*  🞏 🞏 Bronchitis  🞏 🞏 Emphysema  🞏 🞏 Tuberculosis  🞏 🞏 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Bone Conditions**  *Yes No*  🞏 🞏 Osteoporosis: *Medication*:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 🞏 Arthritis: *Type*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 🞏 Artificial Joint: *Type & When*:\_\_\_\_\_\_\_\_\_\_\_  🞏 🞏 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Blood Conditions**  *Yes No*  🞏 🞏 HIV/AIDS  🞏 🞏 Hepatitis: *Type*:\_\_\_\_\_\_\_\_  🞏 🞏 Excessive Bleeding  🞏 🞏 Anaemia  🞏 🞏 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Cancer**  *Yes No*  🞏 🞏 Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 🞏 Chemotherapy: *When*:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 🞏 Radiation Therapy: *When*:\_\_\_\_\_\_\_\_\_\_  🞏 🞏 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please list in the table below any medications you are taking and the reason for taking them:**

|  |  |
| --- | --- |
| Medication | Reason For Taking |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |