 **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 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |