It is practice policy that at the beginning of each course of treatment you must complete a medical history form. Please be assured **ALL** information is **STRICTLY CONFIDENTIAL**.

Have you ever had or are you currently suffering from:

High blood pressure YES / NO

Heart problems, murmur, cardiac surgery YES / NO
Please state____________________

Stroke or TIA YES / NO

Diabetes? YES / NO
Do you take insulin YES / NO

Asthma or chest disease YES / NO

Hepatitis YES / NO

Jaundice YES / NO

Fits, epilepsy, blackouts YES / NO

Arthritis YES / NO

Osteoporosis YES / NO

Neurological disorders (MS, Parkinsons etc) YES / NO

Any form or cancer YES / NO

Any infectious diseases (HIV, MRSA, TB etc) YES / NO

Any bleeding disorder YES / NO

Any disability (learning, sensory, physical) YES / NO

Psoriasis, eczema, other skin conditions YES / NO

Any known allergies to medicines, foods, pollen, latex or rubber products such as balloons or gloves YES / NO

An anaphylactic reaction YES / NO
If YES what to?____________________

A bad reaction to local or general anaesthetic YES / NO

Have you or any relatives been diagnosed with CJD or vCJD YES / NO

Had a dura mater implant YES / NO

Received any form or growth hormone YES / NO

Surgery on spinal cord or brain before August 1992 YES / NO

Please provide the name and surgery of your GP

GP:____________________

Surgery:____________________

Please provide the name and phone number of your next of kin

Name:____________________

Phone:____________________

Are you currently pregnant? YES / NO
Due date____________________

Are you scheduled to have a joint replacement? YES / NO

Taking bisphosphonate medication? YES / NO
(previously or at present)

Do you frequently have cold sores? YES / NO

Do you smoke? YES / NO
How many per day?____________________

Do you consume alcohol? YES / NO
Units per week____________________

Please state **ALL medication** you are currently taking:

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PRINT NAME:____________________

SIGNATURE:____________________

DATE:____________________