

## Medical Evaluation

How is your general health?                      Excellent                      Moderate                      Poor

Are you presently being treated for any medical condition?     Yes  No

If Yes, Treating Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

*Please indicate with a tick in the relevant boxes*

### Cardiovascular

- Coronary / heart attack
- Congenital heart disease
- Hear murmur
- Palpitations / irregular heart beat
- Hypertension
- Stroke
- Pacemaker
- Need for antibiotic cover for surgery

### Allergies

- Any drug / tape allergies (including local anaesthetic/codeine)
- If yes, list drug and reaction:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Psychiatric

- Have you ever received psychiatric treatment                       Yes     No
- Has there been a recent life crisis     Yes     No
- Have you been treated for any drug/alcohol dependency                       Yes     No

### Medication

List any medications you are currently taking and dosage, including alternative medicines (within last month)

\_\_\_\_\_

\_\_\_\_\_

Are you taking aspirin, warfarin, non-steroidal anti-inflammatory medicines or medication containing aspirin?                       Yes                       No

Have you taken any steroid preparation over the past year?     Yes                       No

### Social

- Do you smoke and if so, how many per day?                       Yes                       No                      If Yes: \_\_\_\_/day
- Do you drink more than 2 drinks per day?                       Yes                       No                      If Yes: \_\_\_\_/day
- Can you be supervised overnight by a responsible adult                       Yes                       No
- Do you think for any reason you might be at risk for aids                       Yes                       No

Your Name: \_\_\_\_\_