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:

_____

_____

_____

_____

Chest

- ☐ Shortness of breath
- ☐ Chronic lung disease
- ☐ Chronic cough
- ☐ Asthma

Other

- ☐ Liver disorder/hepatitis/cirrhosis
- ☐ Kidney/bladder disorders
- ☐ Chronic infections
- ☐ Spinal/back disorders
- ☐ Blood clots/thrombophlebitis
- ☐ Any bleeding disorders self/family
- ☐ Blood transfusion
- ☐ Diabetes self/family
- ☐ Autoimmune disease
- ☐ Scarring or keloid formation
- ☐ Are you pregnant
- ☐ Breast disease
- ☐ Breast Biopsies
- Breast cancer (mother/g'mother/aunt)

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)
(INCLUDING FISH OIL)

_____

_____

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

If you undergo a general anaesthetic procedure, 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: _____