

Health history update

Full Name _____
Address _____

Please circle your preferred method of contact, then enter the required information.

Home phone _____ Work phone _____
Mobile phone _____ Email _____

Date of birth _____

Dental health insurance? _____

Are you being treated for a medical condition? _____

Who is your doctor? _____

Are you taking any medications or supplements at present? (Please list)

Do you have, or have you ever had, any of the following medical conditions? (tick boxes)

- | | |
|--|--|
| <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High or low blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Transported organ or bone marrow |
| <input type="checkbox"/> Heart valve disorder | <input type="checkbox"/> Cardiac pacemaker |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Excess bleeding |
| <input type="checkbox"/> Radiation or chemotherapy | <input type="checkbox"/> Hepatitis or other liver disease |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Contact with HIV/AIDS virus |
| <input type="checkbox"/> Heart complaint or heart surgery | <input type="checkbox"/> Anaemia or blood disorder |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Prosthetic implant eg. Prosthetic hip or knee |
| <input type="checkbox"/> Stomach or digestive condition (reflux) | <input type="checkbox"/> Bronchitis, emphysema or other lung disease |
| <input type="checkbox"/> Nervous condition | <input type="checkbox"/> Other |

Details of health condition

Please list all known allergies _____

Do you smoke? _____

For females, are you pregnant or undergoing fertility treatment? _____

Your signature: _____ Date: _____