Medical History…

A ARE YOU.....

1	Attending or receiving any treatment from your doctor,hospital,clinic or specialist?	YES NO	☐
2	Taking any medicines or tablets prescribed by your doctor?	YES NO	☐
3	Allergic to penicillin or any other drug or substance or foods (eg latex/ rubber)?	YES NO	☐
4	4.Pregnant or likely to be so?	YES NO	☐ ☐

B IN THE PAST HAVE YOU....

1	Ever had a heart problem,angina,high or~#low blood pressure,heart attack or stroke?	YES NO	☐
2	Ever had rheumatic fever?	YES NO	☐ ☐
3	Ever had jaundice, hepatitis,liver problems or kidney disease?	YES NO	☐
4	Ever had asthma,bronchitis,hay fever or any serious chest infections?	YES NO	☐
5	Ever had any blood related diseases?	YES NO	☐
6	Ever had a bad reaction to a local or general anaesthetic?	YES NO	☐ ☐
7	Ever had an operation or received hospital treatment?	YES NO	☐
8	Ever had a heart valve replaced?	YES NO	☐ ☐
9	Had a blood transfusion from the Blood Transfusion Service?	YES NO	☐ ☐
10	Had growth hormone treatment before the mid 1980's?	YES NO	☐ ☐

C DO YOU.....

1	Have a pacemaker?	YES NO	☐ ☐
2	Have fainting attacks, giddiness or epilepsy?	YES NO	☐ ☐
3	Have diabetes?	YES NO	☐ ☐
4	Carry a warning card?	YES NO	☐ ☐
5	Bruise easily or have you ever bled excessively?	YES NO	☐ ☐
6	Take, or have you ever taken, steroids?	YES NO	☐ ☐☐
7	Do you smoke? Typically how many a day?	YES NO	☐
8	Have a close relative with Creutzfeldt Jacob disease?	YES NO	☐ ☐
9	Drink alcohol?(A unit is half pint lager, single measure spirit, or glass of wine	YES NO	☐
10	Suffer from headaches or migraine?	YES NO	☐ ☐
11	Suffer from arthritis?	YES NO	☐ ☐
12	Have any infectious diseases, such as HIV,CJD or Hepatitis?	YES NO	☐