Medical History (This form will be checked by the clinician)

Patient name:

Date of birth:

NHS number:

RELEVANT MEDICAL HISTORY FORM ✓ FOR YES X FOR NO			
	Patient is healthy with no known medical conditions		HIV / TB / CJD
	Heart problems		Osteoporosis or bone / joint problems
	High blood pressure		Skin conditions
	Asthma / COPD / Chest problems		Mental health conditions
	CVD/Epilepsy / Neurological conditions / Parkinson's Disease		Bleeding disorders / Coagulopathy / Sickle Cell disease
	Diabetes / Thyroid / Endocrine conditions		Drug dependency
	Gastric disease		Alcohol dependency
	Liver disease / Hepatitis		Allergies
	Kidney disease		Cancer
Have you had, or are currently receiving:			
	Chemotherapy		Radiotherapy to the head and / or neck
	Bisphosphonates (oral / IV), if so please state type and duration in medications box below		Anti-coagulant / anti-platelet medication, if so please state the type and duration in medications box below
Do you have:			
	Learning disability		Visual impairment
	Hearing impairment		Mobility impairment
Please give further details of medical conditions:			
Please give details of ALL medications you are taking (if applicable):			