

TITLE	NAME	DATE OF BIRTH
ADDRESS		
TEL NO.		
WORK TEL.	MOBILE	
DOCTOR'S NAME & ADDRESS		
DR'S TEL.		

ARE YOU:

- | | |
|--|---------------|
| 1. Taking any medication? | YES/NO |
| 2. Receiving any medical treatment? | YES/NO |
| 3. Taking any steroids? | YES/NO |
| 4. Allergic to any medication? i.e. any pills, tablets, or medicines | YES/NO |
| 5. Allergic to any food or materials? | YES/NO |
| 6. Are you a smoker? | YES/NO |

PLEASE GIVE DETAILS:

HAVE YOU:

- | | |
|--|---------------|
| 1. Had rheumatic fever? | YES/NO |
| 2. Had hepatitis or any other blood disease? | YES/NO |
| 3. Had any liver or kidney disease? | YES/NO |
| 4. Had heart disease? | YES/NO |
| 5. Had a heart murmur? | YES/NO |
| 6. Had blood pressure problems? | YES/NO |
| 7. Had a joint replacement? | YES/NO |
| 8. Had a bad reaction to anaesthetic? | YES/NO |
| 9. Been in hospital? | YES/NO |

DO YOU:

- | | |
|--|---------------|
| 1. Have a pacemaker? | YES/NO |
| 2. Have arthritis? | YES/NO |
| 3. Have any chest problems? | YES/NO |
| 4. Suffer from hay fever? | YES/NO |
| 5. Have fainting attacks, i.e. blackouts, giddiness or epilepsy? | YES/NO |
| 6. Have diabetes, or anyone in your family? | YES/NO |
| 7. Carry any warning cards? | YES/NO |
| 8. Have any bleeding problems? | YES/NO |
| 9. Have any other medical problems? | YES/NO |

ARE YOU PREGNANT? **YES/NO**

Completed by: Self / Parent / Guardian. Signature / Date: _____

ADDITIONAL INFORMATION: