

Emergency Contact Details

Name Relationship to yourself

Contact Telephone Number

Your Doctors Details: -

Name

Practice Telephone Number

Your Medical History

Please tick any of the following for which you have been diagnosed or treated by a doctor or health professional?

Asthma Heart Problems Thyroid Disorders Herpes/shingles
Diabetes Multiple Sclerosis Parkinson's Disease Fibro/Polymyalgia
Epilepsy Glandular Fever High Blood Pressure Tuberculosis
Cancer Low Blood Pressure Deep Vein Thrombosis Hemophilia
HIV/Aids Skin Disorders/Infections Bowel or Bladder Disorders Impaired Circulation
Any recent viral or bacterial infection Mental Health Problems or Depression

Do you have a pacemaker fitted Yes/No

Do you suffer from allergies? Yes/No

Please tick if you ever experience any of the following symptoms: -

Pain, pressure, heaviness or discomfort in the chest area
Regular unexplained pain in the abdomen, shoulder, arm, jaw, arms or other areas
Shortness of breath at rest, during daily activities or with mild exertion
Dizziness or syncope (fainting) Sleep apnea Ankle edema (swelling)
Palpitations (abnormal rapid beating of the heart) or tachycardia (rapid heartbeat)
Intermittent claudication (cramping pain and weakness in legs, especially calves during walking)
Known heart murmur (atypical heart sound indicating a structural or functional abnormality)
Unusual or unexplained fatigue Unexplained weight loss
Night pain or night sweats Sudden loss of vision Persistent headaches

Is there a family history of any of the following conditions? (Refers to biological parents and siblings)

Heart Problems	Yes/No	Diabetes	Yes/No	Epilepsy	Yes/No
Early Menopause	Yes/No	Cancer	Yes/No	Other	Yes/No

Have you had any surgery in the past Yes/No.?

Medication, Therapy and Treatment

Please give details of all medicines taken in the last 6 months and list dosages

Are you presently receiving any sort of therapy or treatment? Yes/No.

Ladies

Are you currently pregnant, been pregnant (including miscarriage and terminated pregnancies) or have you given birth in the last 12 months? Yes/No.

Do you have any problems with periods? Yes/No

If applicable at what age did you reach the menopause?

If you have answered YES to any of the questions on this form or have any other health problems, please give details below:

I hereby confirm that the information given above is correct and undertake to notify **Julia Kinsey** of any changes in my medical condition as soon as I am aware of it. I understand that no personal information will be revealed (to my GP or other) without my written consent.

Client's Signature:

Date:

Printed Name: