☐ **Dr Charles Dick** ☐ **Dr Jonathan Dick** ☐ **Dr Kim Latendresse** ☐ **Dr Hans Lombard** ☐ **Dr Dion Noovao** ☐ **Mr James Tunggal**

Health Questionnaire

To provide you with the best possible treatment
Please complete the following.

First Name: ____________________ **Surname** ____________________ **Date of Birth:** DD / MM / YYYY

What is Your Height: __________ cm **What is Your Weight:** __________ kg

Do You Smoke: ☐ Yes ☐ No - **If Yes, How Many:** ____ /day **Do You Drink Alcohol:** ☐ Yes ☐ No - **If Yes, How Much:** ____ /day

Treatment Area: ☐ Left ☐ Right ☐ Both

☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Neck/Back/Pelvis

Medical History
Do you have or have you ever had the following conditions? Please answer every question and tick where appropriate.

	Yes	No		Yes	No
Asthma, emphysema, shortness of breath or other lung problems.			Kidney problems.		
Diabetes. If yes, controlled by: ☐ Diet ☐ Tablets ☐ Insulin			Hepatitis/liver problems.		
Heart attack, palpitations, angina.			Varicose veins.		
Heart murmur.			Deep vein thrombosis (blood clots in the leg).		
High blood pressure.			Pulmonary embolus (blood clots in the lungs).		
Pacemaker or other heart implants.			Previous blood transfusions.		
Elevated cholesterol/triglycerides.			Do you take any blood thinning medication such as aspirin, warfarin, Plavix, or anti-inflammatories?		
Stroke (CVA).			Depression.		
Epilepsy/fits/faints/funny turns.			Neck or back injuries/problems.		
Stomach problems, gastric ulcer, indigestion or reflux.			Problems with anaesthetics, e.g. vomiting		
Bleeding or clotting disorder. Specify: ____________			Do you have any current wound or skin breaks?		
HIV/AIDS.			Have you ever had an MRSA (golden staph) infection?		
Thyroid problems.			Have you ever had a VRE infection?		
Cancer. Specify: ____________			Other: ____________		

Current Medications Including Herbal and/or Natural Therapies: ____________________

Allergies to Medications/Metals/Other**:** ____________________

Previous Surgery Including Dates if Possible: ____________________

Any Complications with **Previous Surgery**: ____________________

Any Problems/Complications with **Previous Anaesthetics:** ____________________

Which of the following causes you to become short of breath: ☐ Exercise ☐ Climbing Stairs ☐ Walking on the Flat ☐ At Rest ☐ Unsure

Do You Know Your Blood Group: ☐ Yes ☐ No **If Yes:** ☐ A ☐ B ☐ AB ☐ O ☐ Positive ☐ Negative

I certify that the information given above is true and accurate to the best of my knowledge and ability.

Signature of Patient/Guardian/POA: ____________________ **Date:** DD / MM / 20YY