

Do you take any medication regularly? YES NO

If yes, please specify: _____

Have you had any bad reactions to medication or treatment before?	YES	NO
<input type="checkbox"/> Penicillin	YES	NO
<input type="checkbox"/> Local Anaesthetic	YES	NO
<input type="checkbox"/> Antiseptics	YES	NO
<input type="checkbox"/> Latex	YES	NO

Have you ever suffered from?

Any long standing illness YES NO

Heart condition YES NO
(Ischaemic heart disease / congestive heart failure)

Rheumatic Fever YES NO

Blood Disease YES NO
If YES are you being treated by a doctor at present? YES NO

Blood Pressure Problems YES NO

Diabetes YES NO

Liver or kidney problems YES NO

Asthma/any lung Condition YES NO

Immune system deficiencies YES NO

Are you at present under any medical treatment? YES NO

Do you suffer from, or have any reason to suspect hepatitis, AIDS or any other infectious disease? _____

Ladies, are you pregnant? If so, how many weeks? _____

Do you have any allergies? _____

Do you smoke, If yes how many daily? _____

Who is your doctor? (Name, Phone number, Address)

All the information I have stated above is true & correct. Please inform us if there is any change to you medical history.

Signature: _____ **Date:** _____

Thank you for taking the time to complete this form. All information on this form is considered confidential. Please note: Due to high costs of surgery operations, a fee will apply for cancellations with less than 48 hrs notice.

Accounts are to be settled at time of treatment.