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| **Name: Date:****Mr/Mrs/Miss/Ms Date of Birth:**  |
|  **Address: Postcode:**  |
| **Occupation:** |
|  **Tel. Home: Email:**  **Mobile:**  |
| **1. Please provide name and contact number in case of emergency:** |
| **2. Do you consent to treatment? Yes/No** |
| **3. Are you on any medication (or have been in the last 6 months)? If yes, please specify. Yes/No**  |
| **4. Are you taking steroids (or have in the last 2 years)? Yes/No**  |
| **5. Have you ever had Rheumatic Fever? Yes/No**  |
| **6. Are you pregnant? Yes/No** |
| **7. Any history of kidney or liver conditions? Yes/No** |
| **8. Have you ever had trouble with your heart? Yes/No** |
| **9. Have you ever had problems with your chest? Yes/No** |
| **10. Any allergies (e.g. hay fever, eczema, food, medications, dressings, latex)? Yes/No**  |
| **11. Have you ever had/have blood disorders? Yes/No**  |
| **12. Do you suffer from high or low blood pressure? Yes/No** |
| **13. Have you ever had Diabetes? Yes/No** |
| **14. Do have a Thyroid Problem? Yes/No** |
| **15. Do you suffer from Rheumatoid Arthritis? Yes/No** |
| **16. Arthritis? Yes/No** |
| **17. Have you ever injured or suffered from pain in the knees, hips or lower back? Which? Yes/No**  |
| **18. Do you have or had Epilepsy? Yes/No** |
| **19. Do you have fainting attacks or blackouts? Yes/No** |
| **20. Have you had surgery or recently been in hospital for any reason? (Please specify in full) Yes/No** |
| **21. Have you ever had a bad reaction to local/general anaesthetic? Yes/No** |
| **22. Have/had any infections such as MRSA, TB, HIV, Hep B or C, Jaundice? Yes/No** |
| **23. Are there any other medical conditions that we should be aware of? Yes/No** |
| **24. Is there a history of illness in your family (e.g. heart disease, diabetes, cancer, other?) Yes/No** |
| **25. Do you use Tobacco products? Yes/No** |
| **26. Do you drink alcohol? How many units per week? Yes/No** |
| **27. Please specify any sensory limitations (e.g. hearing, sight, other) Yes/No** |
| **Shoe size:** |
| **GP name and address of surgery:** |
| **How did you find out about us?** |