

Medical Clearance Form

We need to have an accurate assessment of your health to improve the safety of the procedure. Disclosing a condition will not necessarily preclude you from having the procedure, **BUT**, failing to disclose a condition may endanger your health from the procedure, or lessen the outcome of the procedure. So please tick either "NO" or "YES" for each of the listed conditions that you may have **EVER** had:

	yes	no
Allergic reactions to medications	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reactions in general	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylactic reactions	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Regular coughing and phlegm build-up	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath in slight exertion	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath at night	<input type="checkbox"/>	<input type="checkbox"/>
Pains in the chest	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the feet	<input type="checkbox"/>	<input type="checkbox"/>
Heart arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>
Unusual thumping or beating of your heart	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
History of valve disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
History of Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Family history of anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Bruise or bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in lungs	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulceration	<input type="checkbox"/>	<input type="checkbox"/>
Had an endoscope or colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Smoked cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Do you still smoke?	<input type="checkbox"/>	<input type="checkbox"/>
What year or how many years ago did you stop? _____		
How many do you still smoke?	<input type="checkbox"/>	<input type="checkbox"/>
How many alcohol serves do you have on average per week? _____	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Recent unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes assessment or suspected	<input type="checkbox"/>	<input type="checkbox"/>
Dental procedures	<input type="checkbox"/>	<input type="checkbox"/>
Mole or skin lesion excisions	<input type="checkbox"/>	<input type="checkbox"/>

