Medical Conditions Form

the garden room

First name: _____

Last name _____

Email* _____

Date of birth _____

Day _____

Month _____

Year _____

Do you have or have you ever had any of the following medical conditions?
(Please tick any that apply to you.)

- ☐ Cardiovascular conditions
- ☐ Arteriosclerosis
- ☐ Thrombosis
- ☐ Disorders of the nervous system i.e. ME, MS
- ☐ Recent Operation
- ☐ High/Low blood pressure
- ☐ Asthma/Bronchitis or any other chest condition
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hepatitis/HIV/AIDS
- ☐ Varicose Veins
- ☐ Haemophilia
- ☐ Bruises
- ☐ Allergies
- ☐ Recent injuries or surgery
- ☐ Phlebitis
- ☐ High Temperature
- ☐ Swellings
- ☐ Mental Health Issue

Are you currently receiving medical treatment or on any prescribed medication?

☐ No ☐ Yes _____

Is there anything I should know about which may affect your treatment? ☐ No

I declare that the information I have provided is accurate and complete.

_____