pure™ sports medicine

020 7788 7000
puresportsmed.com

Medical information

Personal details

NAME ..... SURNAME ..... D.O.B D D M M Y Y Y Y

Medical history – do you have any of the following?

	Y	N		Y	N		Y	N
THYROID PROBLEMS	☐	☐	EPILEPSY	☐	☐	RECENT SURGERY	☐	☐
HEART CONDITIONS	☐	☐	ARTHRITIS	☐	☐	CANCER	☐	☐
RESPIRATORY CONDITIONS	☐	☐	DIABETES	☐	☐	ARE YOU PREGNANT?	☐	☐

If yes, please provide details .....

Previous musculoskeletal injury history, including fractures .....

Any other general health issues or concerns? .....
e.g: IBS / skin conditions

Medication

	Y	N	If yes, please provide details
ARE YOU CURRENTLY TAKING ANY MEDICATION? INCLUDING ANTICOAGULANTS (BLOOD THINNING MEDICATION)	☐	☐	.....
ARE YOU CURRENTLY TAKING OR EVER BEEN PRESCRIBED STEROIDS?	☐	☐	.....

Lifestyle

HOW MANY HOURS DO YOU SPEND SITTING EACH DAY? .....

HOW MANY HOURS SLEEP DO YOU AVERAGE PER NIGHT? .....

HOW WOULD YOU DESCRIBE YOUR STRESS LEVELS? HIGH ☐ MEDIUM ☐ LOW ☐

WHAT ARE YOUR STRATEGIES TO MANAGE STRESS? .....

DO YOU HAVE ANY DIETARY OR NUTRITIONAL ISSUES? .....

	Y	N
DO YOU SMOKE?	☐	☐
DO YOU PARTICIPATE IN A STRUCTURED EXERCISE PROGRAMME?	☐	☐

If yes, please provide details .....