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| **Patient Provided Medical Information** |
| **Your Height:** |
| **Your Current Weight:** |
| **Do you** **currently have:** |
| * **Unstable Diabetes** * **Unstable High Blood Pressure** * **Medical problems relating to your heart** * **Pacemaker in situ** * **Sleep apnoea** * **Severe Renal or Liver Disease** * **Are you unable to lay flat and still independently for 10 minutes** * **Any other significant recent medical history? Please comment below:** |
| **Any Previous Eye Related Medical Issues:** |
| **Do you have any Allergies:** |
| **Current Regular Medication:** |