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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:**
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| **Any Previous Eye Related Medical Issues:** |
| **Do you have any Allergies:**    |
| **Current Regular Medication:** |