<u>Patient Provided Medical Information</u>
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 <u>unable</u> 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: