BOTANICA HERBAL CO.

HIJAMA MEDICAL HISTORY / CONSENT FORM

DOB:	Full Name
Address	
Tel / Mobile	Tel: Mobile :
Email	
Your Doctors Name	
Surgery Address and Tel	

Are you currently	Yes	No	Give details
Receiving doctor or hospital treatment	yes		
Taking any Prescribed medicines. e.g. tablets, ointments, Injections, Contraceptives, HRT, WARFARIN	yes		
Carrying a medical warning card		no	

Do you suffer from	Yes	No	Give Details
Allergies to any medicines e.g. penicillin, latex/rubber, foods		no	
Asthma, Eczema or hay fever		no	
Bronchitis or other chest conditions		no	
Fainting attacks, blackouts or epilepsy		no	
Heart problems, angina, blood pressure, Rheumatic Fever		no	
Diabetes		no	
Excessive bleeding problems		no	
Any infectious disease Hepatitis, A,B,C - HIV		no	

D o you have or ever had?	Yes	No	Give Details
Liver/Kidney Disease e.g. , hepatitis		no	
A blood transfusion		no	

Please give details of your ailments and conditions you want treated: (eg medical problem, sunnah reasons)

Patient Signature: _____ Date: _____

Cupping Therapist: _____

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