MEDICAL HISTORY FORM

Title: ..... Surname: ..... First name: .....

Date of Birth: ..... Sex: M/F Occupation: .....

Address: .....

.....

Postcode: .....

Tel: Home: ..... Work: ..... Mobile: .....

Email address: .....

Doctor's name and address: .....

At subsequent appointments please date any changes to your medical history

Are You:	**Yes**	**No**	**Date**
Attending or receiving treatment from any doctor?			
Taking any medicines or tablets from your doctor? Please list :			
Taking/ have you taken any steroids in the last 2 years?			
Allergic to any medicines, foods or materials? Please provide details:			
Likely to be pregnant?			

Have You:	**Yes**	**No**	**Date**
Ever had jaundice, liver or kidney disease, or hepatitis?			
Ever had rheumatic fever or been told that you have a heart murmur?			
Ever been told that you have a heart problem or had a heart attack?			
Ever had infective endocarditis or a heart valve replaced or any form of heart surgery?			

Have You:	**Yes**	**No**	**Date**
Got high or low blood pressure?			
Had any blood tests recently?			
Ever had a bad reaction to a local or general anaesthetic?			
Ever had a stroke?			
Ever had a major operation or recently received hospital treatment? Please provide details:			
Ever been diagnosed or suspected as having V CJD or being HIV positive			

Do You:	**Yes**	**No**	**Date**
Have a pacemaker?			
Suffer from bronchitis or asthma?			
Bruise easily or have you ever bled excessively?			
Have fainting attacks, giddiness or epilepsy?			
Have diabetes?			
Carry a medical warning card?			
Smoke, if yes how many a day? ...../day			
Drink alcohol, if yes how many units a week? ...../week			

Are there any other aspects of your health that you feel we should know about?

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Signed: ..... Date: .....

Signed: ..... Date: .....

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