

Medical History for:			Date:
ARE YOU CURRENTLY:	NO	YES	FULL DETAILS
Pregnant?			<i>(Due date)</i>
Receiving treatment from a doctor, hospital or clinic?			<i>(Details)</i>
Taking any prescribed medicines (e.g. Tablets, ointments, injections or inhalers, including HRT and contraceptives)?			<i>(Names of medicines)</i>
Carrying a Medical Warning Card or other MediAlert device			<i>(Details)</i>
DO YOU SUFFER FROM:			
Allergies to any medicines (e.g. Penicillin), substances (e.g. Latex) or foods?			<i>(What are you allergic to)</i>
Hay fever or eczema?			<i>(Details)</i>
Bronchitis, asthma or other chest condition?			<i>(Details)</i>
Fainting attacks, giddiness, blackouts or epilepsy?			<i>(Details)</i>
Heart problems, angina, blood pressure problems or stroke?			<i>(Details)</i>
Osteoporosis or bone tumours?			<i>(Details)</i>
Diabetes (or does anyone in your immediate family?)			<i>(Details)</i>
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			<i>(Details)</i>
Any infectious diseases (including HIV & Hepatitis)?			<i>(Details)</i>
Cold sores?			
DID YOU, AS A CHILD OR SINCE, HAVE:	NO	YES	FULL DETAILS
Rheumatic Fever or Chorea?			<i>(Details)</i>
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			<i>(Details)</i>
Any other serious illness?			<i>(Details)</i>
A bad reaction to general or local anaesthetic?			<i>(Details)</i>
A joint replacement or other implant?			<i>(Details)</i>
Treatment that required you to be in hospital?			<i>(Details)</i>
Heart surgery?			<i>(Details)</i>
Brain surgery?			<i>(Details)</i>
	YES	NO	IN PAST QUANTITY
SMOKING: Do you smoke any tobacco products now (or have you in the past)? How many a day?			
PLEASE GIVE ANY OTHER DETAILS WHICH WE MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES.			
NAME & ADDRESS OF YOUR DOCTOR:			
Dr		Surgery/Clinic/Health Centre	
FORM COMPLETED BY (Delete as applicable) Self Parent Guardian			
SIGNATURE			